WORLD HEALTH

THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

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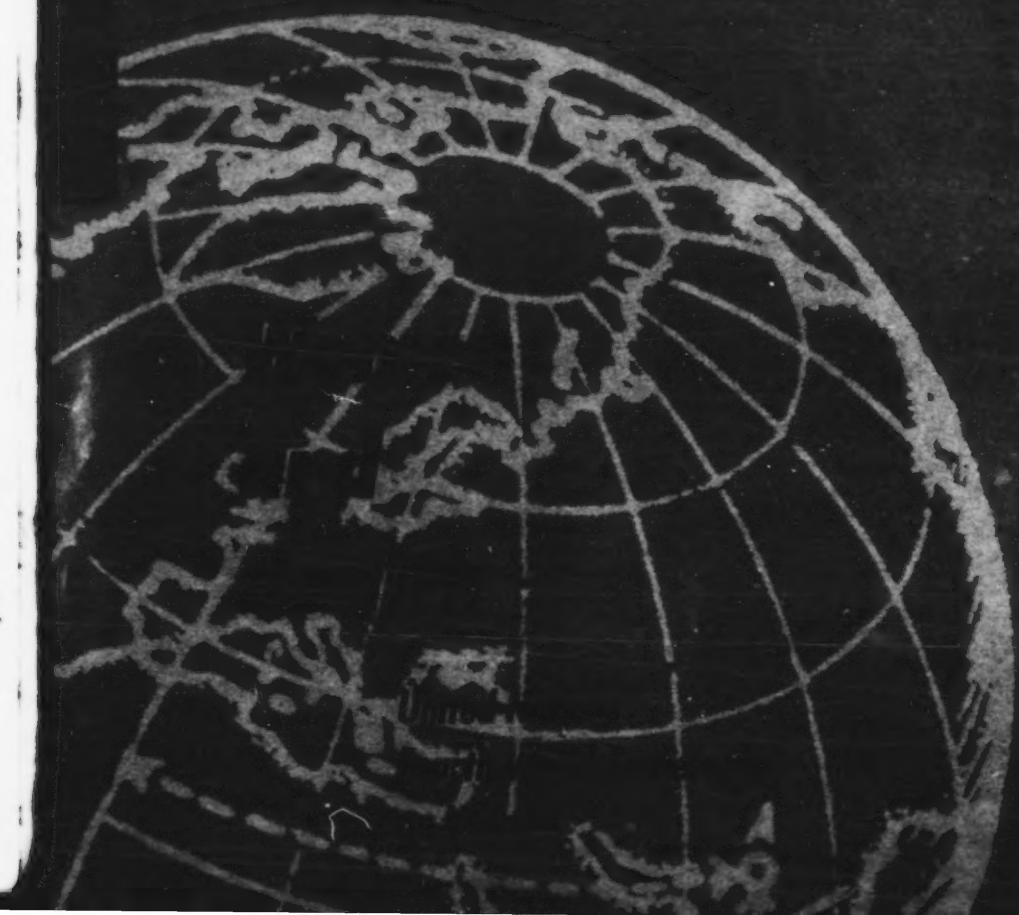

Special Issue

Selected articles on women's issues published recently in World Health

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THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

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This special issue is published in Chinese, English, French and Spanish.

Editorial

Women's health is high on WHO's agenda

WHO/ H. Arenden

Dr Hiroshi Nakajima, Director-General of the World Health Organization

Health, a fundamental human right, is still denied to many women throughout the world, often because their lower social and economic status increases their specific biological vulnerabilities. Such factors combine to affect women's health early in childhood. In many parts of the world, girl children receive less food, less education, less health care than boys. This puts them at a disadvantage both as children and later on as adults. Their reproductive role also imposes particular stresses and risks on women for much of their lives. Half-a-million women die each year, 90% of them in developing countries, from causes related to pregnancy and childbirth. Nearly all of these maternal deaths are preventable. If we want to give equitable care to women and meet their specific health needs, we must integrate reproductive health services into primary health care and make them easily available locally.

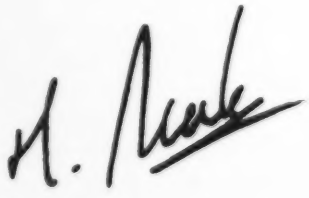
As mothers, women are the front-line providers of care within the family and the key to human development and well-being. Their health, in its turn, has a strong impact on that of the children they bear and raise. Because of this inter-generation link, the improvement of women's health is the surest means of improving children's and family health in general. Our Executive Board has decided to make women's health one of WHO's highest priorities together with reproductive health and family health.

Any sustainable improvement in women's well-being is inseparable from improvements in their social and economic status. This will be achieved by giving women greater power over their own lives, educating them, and providing opportunities for them to earn an income. Women must be recognized as equal partners.

Education is crucial. A woman who has access to education is better able to enhance not only her own health but also that of her family and community. She is better informed on nutritional needs, on the kind of local foods she should use and how she should cook them. She will be able to make her own choices on family planning, to protect herself from cervical cancer and to avoid HIV infection. She will be better able to reject practices that imperil her health. Better equipped to make the right decisions concerning her children and family, she will also be better able to play an active role in improving the society in which she lives.

But women should not be left to shoulder that heavy responsibility alone. Men must help them fulfil their potential and, at the same time, men must also take their share of responsibility in promoting the family's health.

Over the coming years, WHO will pursue the integration of all its programmes which are related to improving women's health and well-being. We will also advocate that all development policies and activities, at both national and international levels, give special attention to reducing inequities in health and fulfilling women's specific needs. WHO welcomes the World Conference on Women which is held in Beijing as a precious opportunity to promote women's health and well-being and their full participation in all aspects of social development. ■



Hiroshi Nakajima, M.D., Ph.D.

Improve our health, improve the world

Aleya El Bindari Hammad

Women's concern for health and their ingenuity in ensuring good health for themselves, their families and their communities, often in the face of great odds, marks them out as a leading force for development and peace.

WHO / J. Taylor

Investing in women's health would accelerate their own efforts

A great deal of information is now available on women's health throughout their lives. While this has been indispensable to the continual assessment of their situation in all parts of the world, unfortunately women often appear as "victims" or as a particularly "vulnerable group".

It is true that women still suffer from unnecessary morbidity and mortality. However, we should not overlook the fact that it is women themselves with their strength and versatility who are responsible to a large extent for improving their own health. We have only to look at the different "health roles" women have played through generations to realize that, if we were to invest in their health and well-being, we would certainly accelerate positive health behaviours.

Women are the primary caregivers in the family. Their knowledge and experience in maintaining, protecting and promoting good health for their families and themselves have been passed down and built upon through generations. Women in all societies have developed proverbs and sayings which ensure that essential health messages are kept alive and passed on. They have demonstrated courage in facing situations of crisis where their very survival and that of their family were in jeopardy, and found solutions to such scarcities as food and water during natural disasters, civil unrest and war. Thus, behind their victimization and vulnerability lies their immense strength which must be built upon for the future. Positive examples can be found all over the world and cover the entire lifespan of women.

Women, with their desire to learn, earn and improve their health and quality of life, have linked economic activities with improved health status. Where formal services have failed to respond to their needs – such as the need for health, social and economic support systems in the AIDS pandemic – women have come together to form their own supportive networks. Similarly, they have formed organizations and networks to ensure that women age with dignity. Where their well-being and livelihood are concerned, women have demonstrated their collective force, for example by succeeding in saving entire forests from destruction despite major pressures. Women have asserted their fundamental right to health and integrity during situations of conflict and war and have denounced the suffering and death by forming human chains against the tanks and guns. Many of these actions are often undertaken at the risk of their lives.

While women often show great ingenuity and courage in defending their right to health and well-being, they also treat both health and disease with a touch of realism, pragmatism and practicality. This is invaluable in all societies and is another positive aspect of their approach to health which can be used to greater advantage in partnership and shared responsibility with men.

How much more could women contribute if they had more information on how their bodies function and on the origins of disease, and comprehensive, relevant education to equip them to recognize opportunities and use each and every one of these for better health? By learning from women's positive experiences, developing partnerships, and complementing their actions with up-to-date information and essential support, women will certainly create an enabling environment that will improve their health, and that of the world. After all, are not women responsible for ensuring that the chain of life remains unbroken? ■

Dr Aleya El Bindari Hammad is Special Representative of the Director-General for Health Policy, World Health Organization, 1211 Geneva 27, Switzerland.

WHO / Ahlin

WHO

Women are the primary care-givers in the family and the community

Why this special issue?

Very few issues of ***World Health*** fail to carry an article on women's health. We thought it appropriate to draw from this wealth of information to prepare a special issue for distribution at the Fourth World Conference on Women being held in Beijing in September 1995. The selected articles reprinted here emphasize different aspects of women's health, as well as the role they play in care-giving and health development. They show how diseases like AIDS or malaria pose special threats to them, how they suffer unduly from the consequences of certain lifestyles such as smoking, and how their health embraces more than just their own well-being: it determines the health status of the entire family, and is a vital element in the development of communities and countries.

Some data may have changed since these articles were published, some of our authors may have new functions or titles, but most facts remain valid and the articles paint a broad picture of WHO's action in the field of women's health and development.

Dr Souad Lyagoubi-Ouahchi
Director, Division of Publishing, Language and Library Services,
World Health Organization, Geneva, Switzerland

WHO / P. Almasy

The family – at the heart of health and human development

Tomris Türmen

WHO / S.P. Noble

What unites all families is love, partnership, common values and a vision of the future

From the dawn of human history, the family has been the at the heart of human development. The family is the first emotional and social support mechanism we experience, our first teacher, our first health care provider. And it is usually the women in the family who assume responsibility for each of these essential functions. Whether the extended family of several generations living in the same household, the nuclear family of mother, father and their children or the single parent family, what unites them all is love, partnership, a set of common values and a vision of the future. Modern times have spawned radical changes which challenge the capability of families to fulfil their functions. Some changes have been positive – modern medicines combined with public health interventions such as sanitation, clean water and immunization have reduced the toll of infectious diseases and permitted many families to emerge from the shadow of death and disease. Other changes, however, such as industrialization, urbanization, environmental degradation, migration and war place great strain on the family's ability to protect its members. Poverty, which affects more than half of the world's population, is the most damaging, for it marginalizes even more those who are most vulnerable – the mother and the child.

Rapid urbanization and migration are creating vast cities where the provision of services cannot keep pace with the influx of inhabitants. Overstretched health infrastructures, inadequate sanitation and water supply, and industrial pollution all have adverse health consequences. Meanwhile, depopulation of the countryside leads to a breakdown in social structures as youngsters move to the cities in search of employment. Political and economic turmoil generates huge flows of migrants and refugees deprived of traditional sources of social and economic sustenance, with resulting heavy stress on the family.

Times of great social upheaval have always resulted in major changes in family life. Very often it is the young who represent the most radical break with traditional values and whose behaviour gives rise to greatest concern. Sexual mores change, access to harmful substances such as tobacco and psychoactive drugs increases, and the elders of the family feel that their authority and wisdom are ignored. But changing behavioural patterns can also be positive as young people develop coping strategies and seek new avenues for self-fulfilment in education and employment.

There are contradictions within all family structures. The family can be a shelter, a system of mutual solidarity and support; or it can be restrictive, hindering individual and social development, even providing the setting for child abuse, sexual abuse, battering and homicide.

The great challenge for public health is to seek ways to empower families to do well what they do best, and this requires the support of the rest of society. Families are central to human development, but they cannot do the job alone; a positive relationship between families and the health sector is essential.

The International Year of the Family in 1994 reminds us all of the crucial importance of the family in maintaining an optimal level of physical, mental and social health for its members, to the ultimate benefit of all of us. ■

Dr Tomris Türmen is Director of the Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

The family of tomorrow: a message from a world-famous author

In order to be successful, the family ought to embrace several generations, since it is essential for the young and the less young to live together, understand one another and help one another. I have no doubt that the future will see the "extended" family being recreated, in the sense that it will not be based simply on the notion of blood relations but rather on ties of affection.

The future seems likely to see a crucial change in the role of the family, which will become the initial training centre where people are apprenticed for life in society.

Even more vital will be the revival of what used to be called the "extended" family, which knits together basic family units. This "joint family" comprising relatives in the broadest sense was what constituted Chinese and Indian society in the past. I myself had the good fortune to live in one of those "large" families – good groundwork for being able to adapt very easily to the most varied settings and personalities. Better still, I come from a complex family, mixed Chinese and European, so that I was never trapped within one single culture or forced along one single path; consequently I can take the broad view that the whole world seems like one vast family... Distrust and fear have no part in it, and there is no need for protection. This large family is not a fortress but rather an access route to everyone and thus the true cradle of society.

I have no doubt that the future will see this large "extended" family being recreated, in the sense that it will not be based simply on the notion of blood relations but rather on ties of affection. When the young people of North America tried in the 1960s to form such communities, they failed because all who were not of the same generation were excluded... Yet children yearn to belong to a great family; one has only to see the gangs of youngsters in the streets of our big cities to measure this need.

In order to be successful, this "family space" ought to embrace several generations, since it is essential for the young and the less young to live together, understand one another and help one another. Within a family at its basic level, the child can be lonely. In the bosom of the extended family it will never be lonely, because if the mother is absent there will always be the grandmother, the sister, the cousin or the aunt. Thus the child is not fixated exclusively on its mother since the very notion of motherhood is itself extended. The future will undoubtedly rediscover this family–community structure, particularly since technological advances make it possible for a lot of work to be done at home, thus avoiding useless and exhausting travelling.

Let me say again – because it is crucial – that the extended family can resolve at a stroke all the problems of unequal talents and unequal success which otherwise arouse that devastating emotion – human egoism. The function of the family is to level out inequality. ■

Extracted, with the permission of Mrs Han Suyin from Les yeux de demain (The eyes of tomorrow), published by Christian de Bartillat, Paris, 1992.

The key to child survival

Adelphe S. Mabelay & Vida Sabingsabing

Named after the local word for the youngest child in the family, BUNSO is a national coalition promoting and protecting the health and rights of mothers and children.

WHO/ M. Cooper

Breast-feeding: key to child survival

Ten years ago, a dairy company dumped on the markets of the Philippines the time-expired and vitamin-deficient milk base of an infant formula drink. When this became known, it sent consumers protesting on the streets and in parliament. While the movement failed to stop the company from selling more of this product, it succeeded in raising consumer awareness. This later found expression in organizations and community actions which vigilantly kept watch over consumers' health rights, particularly those pertaining to mothers and children.

From these beginnings, a multisectoral coalition of community-based groups was born in 1981 to pursue the protection of infants' health. The group was named BUNSO, the Pilipino vernacular for the youngest child in the family. BUNSO was committed to promoting material and child health, with emphasis on breast-feeding as the superior mode of infant feeding.

Infant mortality in the Philippines stood at 51.5 per 1000 live births in 1989. This meant that for every 1000 live births, 52 would die before they reached the age of one year. Two-thirds of these deaths would be due to infectious diseases – with pneumonia and diarrhoea diseases topping the list – and malnutrition.

Breast is best

This situation was aggravated by the decline in breast-feeding rates which fell from 87% in 1973 to 80% in 1984. Despite the scientific recognition that breast-milk provides the ideal nourishment for infants, a BUNSO study of infant feeding practices in several government hospitals revealed that breast-feeding was practiced by a mere 41% of the mothers sampled. Breast-feeding was lowest among women in urban areas.

Conscious of this alarming trend, BUNSO initiated various activities aimed at reviving the popularity of breast-feeding, a practice so essential to child survival and yet so gravely threatened with extinction. BUNSO's membership was drawn from such community-based groups as consumers, the church, health workers, women, and the urban poor, and this ensured widespread participation.

Through the joint efforts of these groups, BUNSO struggled to get approval for the Philippine Milk Code, which seeks to regulate the marketing and distribution of breast-milk substitutes, supplements and related products. Designed by BUNSO, other nongovernmental

organizations and the Department of Health in 1983, the Code finally became operational in 1986.

Now that the Code is in place, its sponsors are currently monitoring the marketing and advertising practices of dairy companies to ensure that its provisions are not violated. Milk Code advocacy is actively being pursued to make more consumers aware and assertive of their rights.

Community participation in this field is not limited to Code monitoring and advocacy. In 1984, BUNSO conducted breast-feeding seminars for pregnant and lactating mothers in 11 poor urban areas in Metropolitan Manila. Some 1000 mothers underwent training on the advantages of breast-feeding, the disadvantages of bottle feeding, and correct breast-feeding techniques.

In time, mothers were not only breast-feeding their infants but were also actively advocating breast-feeding within and outside their communities. Mothers figured prominently in BUNSO-sponsored motorcades calling for stricter implementation of the Code. Eventually, they received training to help them in planning and running their own community programmes.

WHO/ S. Yoba

Mothers play a key role in ensuring immunization against childhood diseases

Mothers' best friend

The success of BUNSO's community work led to the development of Breast-feeding Mothers' Counsellors. Each counsellor is trained to provide guidance and support to pregnant and lactating mothers: she invites mothers to a breast-feeding class, and later makes house visits to advise them if they are having problems with breast-feeding or simply to make sure they get all the support they need.

The counsellors, together with the mothers, represent a defence line to counter misleading information which might discourage pregnant and lactating mothers from breast-feeding. This system also encourages mother-to-mother counselling and support.

In 1989, a lactation centre was set up in East Avenue Medical Centre, where Breast-feeding Mothers' Counsellors were able to aid women who gave birth in this Quezon City government hospital. Subsequently, facilities offering a similar package of services were set up in health centres near the community.

BUNSO's breast-feeding programme continues to explore and expand into new spheres in order to make its activities more responsive to the needs of mother and child. It works in cooperation with the maternal and child health and nutrition programmes of BUNSO, distinct but part of the same mother and child concern.

This year, BUNSO has targeted the setting up of support systems in communities and factories to make breast-feeding easier, especially for working mothers. It is also studying the possibility of income-generating projects to augment the community's income.

The guiding principle of BUNSO's work is to support mothers' groups by getting them interested in counselling mothers, managing infant health care services, and starting livelihood projects. Through these, it is hoped that the community may regain self-reliance and self-esteem. Only through building community awareness about proper child health and nutrition, by equipping people with proper skills, and by actively engaging the community can BUNSO's objectives be achieved. ■

Ms Adelpha S Mabuloy is Secretary General of BUNSO and Ms Vida Subingsubing is the Resource Centre Coordinator. BUNSO's address is 5 Basilan Street Philamlife, Homes, Quezon City, Philippines.

Community action

Women's action for health development

Kardinah Soepardjo Roestam

Women in Indonesia are playing an increasingly large part in economic activity and community development, in addition to their domestic responsibilities. Over 40% of the country's workforce of 86 million consists of women. Recognizing their importance in national life, the government has established the State Ministry for Women's Affairs with the aims of fostering their well-being and harnessing their potential for the benefit of all. Considerable progress has been made, notwithstanding shortages of funds, facilities and trained personnel at the grass-roots level.

WHO / T. Farkas

The author of this article, who was President of the 1994 Technical Discussions on Community Action, is seen here with Dr Hiroshi Nakajima, Director-General of WHO.

Delegates to the World Health Assembly and other health experts are invited to participate in Technical Discussions on a chosen theme of importance for international public health. In 1994 the theme was "Community action for health", with the accent on the need for a dynamic partnership between health professionals and individuals in the community so as to ensure a focused improvement in each community's health status.

Community development projects

Management and leadership training programmes for women are being conducted, and self-help is considered vital in community development projects, which have the following characteristics.

- Women whose work is primarily in the home are being trained in handicrafts and other skills with a view to selling produce in local markets.
- Integrated health posts or *posyandu* are being developed in hamlets, villages and neighbourhoods. Questions of water supply, sewage and garbage disposal, and the quality of house construction are being addressed. Health service interventions are underpinned by health education, and communities obtain technical support from their local health centres. Communities are encouraged to provide finance to meet their own requirements in the health field.
- A special effort is being made to eliminate illiteracy. Reading materials contain messages on health, hygiene, sanitation, environmental cleanliness, and economic and agricultural subjects.
- A religious and cultural basis is considered to be necessary for the development of socially responsible attitudes and behaviour in relation to health and other matters.

P. Th. Jansen

Women working in local industries can improve the income of the family.

All Indonesian civil servants and their families enrol in the state health insurance scheme, which is funded by a levy of 2% on basic salaries. Members are entitled to free treatment, including the provision of

drugs, at government health centres and hospitals. *Dharma Wanita*, an organization of the wives of civil servants, has signed a memorandum of understanding with the scheme whereby a programme of health promotion and disease prevention is being set up.

In Jakarta, where the scheme has almost a million members, surveys have been conducted on disease patterns, utilization of the health services, and related matters, and the findings have led to the initiation of health education projects and the holding of seminars on self-care. Attention is given to the prevention of communicable diseases such as conjunctivitis, worm infection, and AIDS, and of non-communicable diseases, among them heart diseases, diabetes mellitus and hypertension.

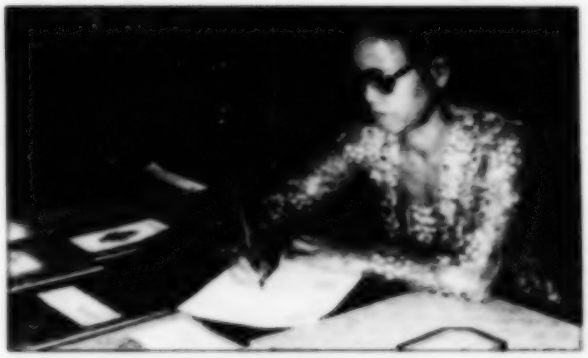
WHO / P. Johnson

Family welfare is the main target of community action for health

Village-based health insurance and care

Dana sehat is a village-based health insurance scheme in which funds or marketable commodities are gathered in accordance with the tradition of mutual aid within the communities, known as *gotong royong*. The prime movers may be local leaders, local government staff, people working in nongovernmental organizations, including women's organizations, and ordinary members of local communities. Over 4000 villages have *dana sehat* schemes, covering about a million households. Some examples follow.

- A pilot prepaid community health programme was inaugurated during 1987 in Kerambitan Subdistrict, Bali Province. The target population comprised some 30 000 people in 15 villages. A survey indicated that 57% of the people desired only basic outpatient care, 5% wanted only inpatient care, and 27% preferred a combination of both. A preference emerged for a programme providing access to both public and private facilities. On these grounds it was decided to provide basic services, referral services and inpatient care, using the personnel and facilities of the two sectors. The running of the programme is greatly helped by the existence of the traditional *banjar* or hamlet organization and Pembinaan Kesejahteraan Keluarga (PKK), the Indonesian Family Welfare Movement.
- In 1988 a *dana sehat* movement was started in Candiroto Subdistrict, Central Java Province, with a potential membership of 49 000 people. The basic ideas were promoted, focus group discussions were held, meetings were arranged with village representatives, an operational plan was formulated and contributions were collected. Management of the scheme is in the hands of a village cooperation unit. The PKK has played an important role, especially in encouraging families to participate. The monthly payment is Rp 100 per person, 25% of which is retained for village activities connected with the scheme.
- In Jakarta a scheme is in preparation for the benefit of home handicraft workers and small-scale traders and food manufacturers. The initial steps being taken by health providers are similar to those outlined above for the Candiroto Subdistrict.



WHO / P. Johnson

Women's organizations participate in establishing health insurance schemes

Village polyclinics where women can give birth are maintained, managed and financed by local women's organizations. *Dharma Wanita* is involved in similar work, whereby rooms are provided by families in village houses for this purpose. The patients, accompanied by family members, have the opportunity to use the accommodation before, during and after delivery. Charges are made to cover the costs of maintenance, hygiene, sanitation, delivery, health education, demonstration of supplementary feeding, referral and so on.

Women, therefore, acting individually, in small groups, or through major nongovernmental organizations, now play a vital role in the development of health care in Indonesia. They are in a good position to disseminate information on health insurance, and educational programmes on this subject should therefore be directed at women's organizations. With a view to expanding community health insurance schemes, studies should be made on the perceptions, attitudes and knowledge of women in this field. Finally, it is necessary to improve the services provided under such schemes, to understand the constraints and problems they face, and to formulate action programmes based on mutual aid. ■

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Women's health in Europe

Mireille Didier

WHO / Taha

Good family planning entails an equal sharing of responsibility between men and women

As the 20th century draws to a close, we have witnessed a genuine revolution for which women have been waiting for thousands of years: at last it has become possible to control reproduction. From the contraceptive pill to the intrauterine device (IUD), from spermicidal suppositories (which destroy the male spermatozoa) to the good old condom (which has the added advantage of being the only effective way to prevent the sexual transmission of AIDS), there is a wide choice of simple, safe and effective methods for avoiding an unwanted pregnancy.

Proper facilities

Yet women and their partners still need to have access to them and to learn how to use them. Moreover, the psychological and social mechanisms governing the woman's choice as to whether or not to have a child at a given moment are highly complex. This explains why, despite the ready availability of contraceptive methods, we cannot hope to see unwanted pregnancies disappear completely. It is therefore all the more important to make sure that proper facilities are available for women who do not wish to continue with such pregnancies.

Experience proves that, if family planning methods are to be used properly they must be accompanied by genuine sex education provided by professionals and volunteers. Respect for cultural habits and religious convictions, and a kind of apprenticeship in responsibility on the part of both partners, are essential prerequisites for efficacy in this field. In order to ensure that every child born is a wanted child, every woman's right to choose the means for fulfilling her sexual and reproductive life must be respected. ■

Mrs Mireille Didier is a freelance journalist based in Paris. Her address is: 2 Square Bartholomé, 75015 Paris, France.

Invisible agents for change

Perdita Huston

If sustainable development is the latest challenge to the international development community, then women, more than ever before, should be at the front and centre of all action strategies. This is not a matter of social justice, nor a feminist issue; it is simple common sense. Sustainable development, according to the Brundtland Commission, "is development that meets the needs of the present without compromising the ability of future generations to meet their own needs."

The complexities of sustainability suggest an equation with three essential components: wise use of natural resources and eco-systems + equitable development strategies + population policies and family planning service = sustainability of natural systems and socioeconomic productivity. But if one of the three is eliminated, the chances of achieving sustainability are threatened. And if we examine the roles (productive and reproductive) that women play – on a daily basis – in most societies, women's involvement in all three components is clearly essential to success. The interaction of women with the natural resources upon which family livelihood are dependent (soil, water, forests), their role in family sanitation and waste disposal, and their contribution to natural resource management far exceed those of men in the non-commercial sector. In the case of energy consumption, women's role as fuel gatherers, tree planters and users of fuel-efficient stoves are critical elements in national energy policy and planning. And if 80 per cent of family food in Africa is produced by women, the implications for agricultural policy are also evident.

But what about the third component of the equation – population policies and family planning? Very simply, without control over their health and fertility, women will not be able to participate fully in development efforts. Recent data demonstrate the enormous health benefits – for both mother and child – of family planning. One out of five infants' deaths in developing countries would be prevented if all births were separated by an interval of at least two years. The World Bank estimates that 500 million couples who do not want more children do not use modern contraceptive methods, due mainly to the unavailability of family planning services.

Over one-third of the 140 million women in the developing world who have become pregnant in the last 12 months did not want to have another baby; 200 000 among them have died in that period from unsafe abortions. Millions more suffer from permanent disabilities or chronic illnesses. Malnourished, married too early, bearing children too soon after giving birth or too late in life and without adequate maternal health services, women continue on their tragic course.

At the same time, with population growth rates overtaking economic growth and productivity, the government services are over-stretched, unemployment soars and natural systems are over-exploited. At the individual and national levels, family planning thus becomes an essential element of development, social justice and the well-being of human and natural resources.

Development strategies in the past, which relied heavily on measurements of gross national product (GNP), ignored the silent partners of development. Mother Nature's bounty had no monetary value: it was there to be exploited, sold, ploughed up, cut down or polluted. Until her wounds became visible to the naked eye or her despoliation resulted in natural disasters, we paid little attention to her sustainability.

The other silent partners, the women, have also remained invisible. Worse still, they have been deprived of equitable participation in development and its benefits.

In our search for sustainable development all partners become essential to success. Women, as productive agents for change must be empowered as equal partners. Empowerment means recognizing the value of women's work – as well as their right to, and need for, family planning services. ■

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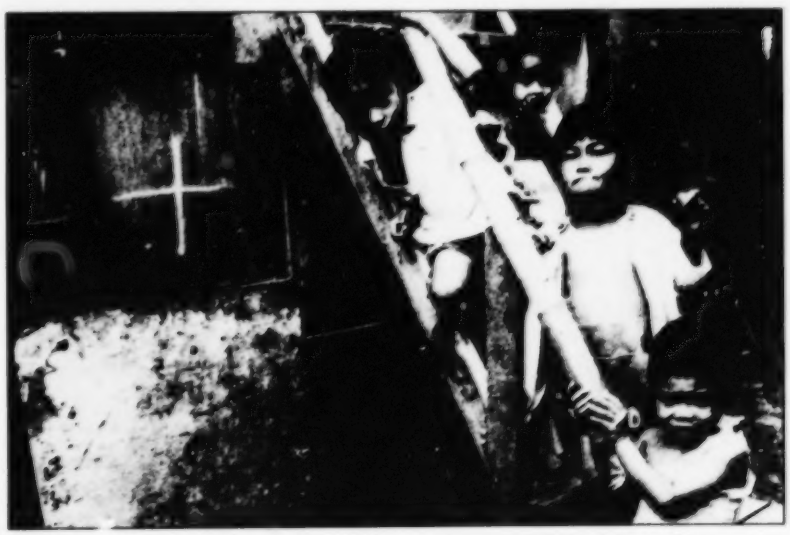

A mother and her growing family in Thailand. "Without control over their health and fertility, women will not be able to participate in development efforts".

What do women want?

T. K. Sundari Ravindran

WHO / I. Taylor

The choice of a fertility regulating method depends on many factors, including affordability

Almost 30 years after the contraceptive revolution of the 1960s, there are 300 million couples in the world who do not want any more children but are still not using any form of contraception, when there are more than 70 different types of contraceptive pills, at least 20 IUDs and four types of injectables, barrier methods, and female and male sterilizations.

Take the case of Gowri, aged 29, a poor wage labourer living in a small town in South India who is anxious to avoid any future births, but has not found a suitable method of fertility regulation. She has had six pregnancies and borne five children, of whom only the fourth and fifth survived. The first was a stillbirth while the second, a girl, was born mentally retarded and died after the second year. The third, a low-birth-weight baby, did not survive beyond the first hour.

"I was heart-broken. My husband had turned to another woman because I was unable to bear him a live child. When the fifth child was barely a year and a half, I was pregnant for the sixth time. That was when I decided to have an induced abortion to ensure that the two precious ones grew up healthy and well cared for."

Being dependent on daily wages for survival, she could not afford the long delays involved in seeking help from a government hospital. She borrowed money and went to a private clinic, where she had an abortion and had an IUD inserted right away. Following this, her menstrual bleeding lasted nine to ten days instead of five. Already malnourished, she became acutely anaemic. Then she developed an infection of the reproductory tract during the second year, mainly because of the lack of privacy, limited access to water and inability to afford adequate sanitary protection during menstruation. This seriously disrupted her ability to do strenuous work, and in addition the medical treatment proved very costly.

Unable to continue with the method, Gowri switched to oral pills bought across the counter. But she could not afford to buy them month after month. She also had spells of dizziness and vomiting, and felt very weak and unwell. "I often had to take breaks during work and lie down for a while." Soon, no one was willing to employ her since she was considered sickly. This left her with no choice but to discontinue the pill. Tubal ligation is the only other option available, but she has reservations. Her children are still too young, and she wants to wait till they live to be older. In addition, she has no one to take care of them, or of her, after the surgery. She could not afford to stay away from work for several days, either. Expecting her husband to adopt birth control is a hopeless idea, since he now has another family, and visits Gowri only once or twice a week.

Facing realities

For women, the safety of any contraceptive method is defined in relation to whether it has adverse health effects that limit their ability to carry on their normal daily tasks, and to earn a living; whether these effects involve costs for medical treatment to alleviate the symptoms; and whether they cause or accentuate marital tensions because of the effects on the woman's physical and emotional well-being, and on her libido.

Acceptability too is based mainly on factors such as the point at which women are in their reproductive life-cycle and their reproductive history. Women who have suffered child losses and pregnancy wastage would not accept methods that may interfere with their fertility – present or future. Young women who have not begun childbearing and women who plan to have additional children may find a less effective method acceptable, especially if it is free of health risks – as in the case of natural family planning or barrier methods. Women who are wage-earners may be unable to afford taking time off work to go to the clinic regularly, for injectables or to replenish supplies of oral contraceptives. Thus, acceptability of a method is assessed by women according to the circumstances of their lives; they are likely to vary for different women, and for the same woman at different points in her life.

WHO/T. Taylor

Fertility control should be a matter for both partners to decide on

Male-dominated society

Acceptability of a contraceptive method is also judged within the parameters of a male-dominated society. Men rarely come forward to undergo sterilization, and are usually unwilling to use the condom especially for contraceptive purposes. Often, women themselves reject the idea of male sterilizations, because they do not want the "breadwinner" to take any risks with his health.

In discussions with poor women in rural India, I often heard remarks such as the following:

- "I do not trust the service provider to remove the implant if I have a problem. I do not want to risk it."
- "They (service providers who are part of the government's family planning programme) do not take responsibility for treating reproductive tract infections that may follow IUD insertion; you have to seek help from private doctors, and that costs money."
- "I am afraid of all methods. All of them have problems, and the service providers don't care."

Thus, many of the reasons why women do not find a fertility-regulating technology that suits them have to do less with the technology itself, and more with their poor health and overall status; with male control over female sexuality and men's unwillingness to take responsibility for fertility control; and with a poor health infrastructure and quality of care. What is needed is a search for policies and programmes that will remove these constraints.

More importantly, women's needs and concerns should be the starting point on which the development of new fertility-regulating technologies are based. This would involve the search for methods that are not only free from adverse health effects but also provide protection from reproductory tract infections and HIV/AIDS; that are reversible and do not adversely affect future fertility; that do not interfere with lactation; and that are in addition effective, easy to use and affordable. It would also mean according a high priority to the development of a wide range of contraceptive methods and devices for men. ■

WHO/T. Taylor

Poor health and low overall status are often barriers that prevent women from using contraception

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Female circumcision

Hamid Rushwan

Female circumcision is one of the more harmful traditions still practised in many parts of the developing world. The custom involves removing some or most of the external female genitalia, usually accompanied by a traditional ceremony, and generally before the girl reaches puberty. The term "genital mutilation" has increasingly been used to try to indicate the tragic effects of the more drastic forms of female circumcision.

Recently there has been great interest in the subject in countries where it is widespread. The purpose of discussing this sensitive subject is to focus attention on the harmful effects this practice has on the health of women and children. In this context it is also important to mention that female circumcision is a major public health problem, the management of which constitutes an immense burden on the already strained health facilities of those countries in which it is practised.

Female circumcision is usually performed on girls when they are seven or eight years old, although some African tribes perform it on infants and other societies on young adult women. It is usually performed by traditional birth attendants, midwives or an elderly woman in the village with experience (but by no means necessarily any medical training). In such circumstances, the operator has no surgical skill and operates under poor hygienic conditions, using an unsterile knife or sometimes a sharpened stone, and no anaesthetic.

The severity of the operation is generally differentiated into four basic types. Type 1 is analogous to male circumcision and consists of cutting the clitoral prepuce circumferentially to remove it. This is the least drastic type. Type 2 involves removing the glans clitoris or even the entire clitoris; part or even all the adjacent tissues (the labia minora) may be removed as well. Type 3, infibulation or "pharaonoic circumcision," involves removing not only the clitoris and adjacent tissues (labia minora), but the external labia as well; the raw edges of the wounds are then sewn together leaving only a tiny opening for urination and menstruation. Type 4, which is rarely practised, is referred to as introcision and involves enlarging the vaginal opening by cutting the perineum.

WHO/J.C. Bauer

A young girl facing puberty in Sudan. Female circumcision is a harmful traditional practice that is still widespread in many countries.

An estimated 84 million girls and women in the world today have undergone some form of female circumcision.
Women in the World: an International Atlas. Simon and Schuster, New York, 1986

Medical consequences

Many medical complications – immediate and long-term – arise from this procedure. Bleeding is unavoidable since damage to the blood vessels is inevitable. Shock, both from loss of blood and pain – since the procedure is performed without anaesthetic – also invariably occurs to some degree and in some cases can lead to death. Infection is a common complication due to the unhygienic conditions in which the "operation" is performed. Tetanus and septicaemia (blood poisoning) also occur and can prove fatal. Urine retention occurs in virtually every girl during the first few days after the procedure. Due to pain, fear, and swelling of the tissues, the girl is unable to urinate, resulting in additional pain for her and possible urinary tract infection. Damage to other tissues surrounding the genitalia may occur, including the urinary canal, vagina, perineum or rectum.

Long-term complications can cause suffering for many years. Hardening of the scars (keloids) can cause problems at the time of first intercourse or at delivery. Cysts can develop as a result of external skin being sewn into the circumcision wound. These cysts can reach a huge size, requiring surgery to remove them, or they can become infected, forming abscesses. Menstrual problems occur often, including retention of menstrual blood because the remaining opening after circumcision is too small to allow adequate drainage. This inadequate drainage is also responsible for the accumulation of menstrual debris and urinary deposits in the vagina; these can form "stones" in the vagina that cause tears (fistulae) in the tissue separating the vagina from the urinary tract and the bowel, resulting in leakage of urine and faeces which in turn creates many social problems for the

woman. Fistulae can also be the result of obstructed labour due to the vaginal opening having been nearly closed by the circumcision.

Infertility may occur because sexual penetration is so difficult or because of pelvic inflammatory disease from chronic infection. Sexual problems are common in circumcised women especially early in marriage, to the detriment of the marriage relationship. Finally, many psychological problems as a result of circumcision have been reported, including anxiety, depression, neuroses and psychoses.

The origin of female circumcision stretches far back in history, and it has been practised in many parts of the world. Today, the practice survives primarily in large areas of Africa among a variety of tribes. It is common from the East Coast of Africa to the West, from Ethiopia to Senegal, and from Egypt in the north to Tanzania in the south. Excision is also practised in the southern end of the Arabian Peninsula along the Gulf.

Less severe forms of female circumcision have been reported from Malaysia and Indonesia. Some African and Middle Eastern immigrants to Europe and the United States continue to practise circumcision on their daughters in their adopted homelands. In some cases, this has resulted in criminal prosecution of the parents by the authorities in those countries, usually because the child died of complications from the circumcision.

How has female circumcision become so entrenched a custom for those communities which practise it? Its proponents are hard-pressed to produce reasons to justify it.

One of the most frequently offered reasons is that female circumcision is demanded by the Islamic faith. This is not true, as has been emphasised by Islamic theologians, and the practice is rarely seen even in the cradle of the Muslim religion, Saudi Arabia, and other neighbouring Muslim countries. Still, some people continue to do it under this erroneous assumption. More than 50 per cent of the male respondents in a survey conducted in Sudan in 1983 expressed the belief that female circumcision is a Muslim religious requirement. This mistaken belief is very important to consider when strategies are being drawn up to abolish the practice.

In the same Sudanese survey, 41 per cent of women interviewed said they believed it is a good tradition because it promotes cleanliness, increases a girl's chances for marriage, improves fertility, protects virginity, and prevents immorality.

"Long ago my sister died after circumcision. She couldn't pass urine and was not taken to a doctor. One of my daughters, circumcised the pharaonic way, had the same trouble, together with a fever. The doctor did a de-circumcision." – *A married woman, 47 years old, illiterate.*

"I have been circumcised pharaonically. My daughter, who is 17 now, has not been circumcised. I told her she didn't have to be grateful to me for anything in her life, except that she is uncircumcised." – *A married woman, no age stated.*

"My mother, sisters and wife have all had pharaonic circumcisions. So will my daughters. This has nothing to do with Islam but sometimes society governs people's lives." – *A married man, 33 years old, teacher.*

Abolishing the practice

Female circumcision is a harmful traditional practice that should be regarded as a public health problem in the countries concerned. Concerted efforts on the part of many sectors of society are therefore needed to help abolish the practice, since "traditions die hard."

Public education is the first step in the campaign, using all available mass media to highlight the health and social problems that may be caused. The formal education system is also an important means of exposing the hazards of female circumcision. Health workers at various levels of the health care system will play a vital part in bringing public education to the "grass roots." In particular, educating midwives and traditional birth attendants about the dangers of the practice and enlisting their help in the campaign to abolish female circumcision will be of the utmost importance since these are the people who usually perform the "operation." One difficulty is that they are usually financially dependent on the practice for their livelihoods. Winning their support in the campaign to eliminate circumcision would be a major step forward.

The role of religious leaders is also extremely important in reaffirming that female circumcision is not demanded by the Islamic faith. Women's groups too should be involved in this campaign since the custom is regarded by many societies as a women's concern.

WHO's Eastern Mediterranean Regional Office has, long ago, urged member countries to adopt national policies aimed at the abolition of female circumcision, and to demonstrate to traditional birth attendants and other practitioners of traditional medicine the harmful effects of this custom.

In the past, laws have been enacted to punish those who practise female circumcision, but these have not proved successful in deterring the custom. It is essential that every community in which female circumcision is prevalent should study the problem carefully and accordingly design a strategy for dealing with it that takes into consideration the local situation. It may take a long time to succeed, but an urgent effort is needed to put an end to the suffering of *millions* of women and little girls. ■

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Social cost of maternal deaths

Oratai Rauyajin & Bencha Yoddumnern-Attig

The impact of maternal mortality on the individual, the family and society at large is like a pebble dropped into a pond, where the ripples of action and reaction reach out to all shores. In Thailand, the problem is causing particular concern.

In countries with especially traditional societies, women whose biological function is to reproduce the species have a significant role in motherhood, and their social status is based on their abilities to fulfil this role. Generally, childbirth is a joyful event for a family and the community. Yet safe motherhood has long been neglected by policy-makers as an important prerequisite for national development. Consequently, many thousands of such mothers have been dying in developing countries.

As far back as 1942, Thailand's Ministry of Public Health was concerned about maternal mortality and established a Maternal and Child Health Division within its Health Department; this Division was later renamed the Family Health Division. Its main duty was to expand maternal and child health coverage over the entire country. The basic strategy was to train auxiliary midwives to staff a number of midwifery centres that would provide expanded services at the district level.

During the past decade, the Ministry has strengthened the maternal and child health services in order to achieve maximal coverage of both curative and preventive care at all levels. The programme focused on increasing community participation and involvement to increase service accessibility and acceptability. In line with WHO's Safe Motherhood Programme, the Ministry has launched many other programmes aimed at halving the present mortality rate by the year 2000, and carried out a pilot study for improving the services through the primary health care approach, targeting high-risk and special minority groups.

In terms of the country's developmental future, the maternal mortality rate is still high and is one of the leading causes of death. This is especially the case for women living in remote rural areas as well as among the minority Muslim population in southern Thailand. These mothers represent the vulnerable groups in need of immediate interventions, since they have the least access to services due to physical, social and cultural barriers.

Maternal mortality

A one-year nationwide survey of maternal mortality collected data in 1989-90 from medical records and death certificates about mothers who died in hospitals, clinics, health centres and other health service units run by the government and private organizations. Results showed that the nation's maternal mortality rate was 2.7 per 1000 live births, but this varied depending on the region under study. The highest rate was in the south (5.0 per 1000 live births) and the lowest in the central region (1.1 per 1000 live births). Most maternal deaths in the south came about because the mountainous terrain restricts access to government health services. Furthermore, certain traditional childbirth practices are inappropriate, and many mothers are attended by traditional birth attendants and had no antenatal care.

The social costs of maternal mortality are enormous, but they fall most harshly on a woman's traditional role of mother and on the children under care. An old Thai proverb reflects the consequences of maternal mortality. It says, "*Without a father, a child's life will be hard; it will have no direction. Without a mother, the situation is even worse – the same as a sinking boat or broken ferry.*"

Traditionally, a child whose mother died in childbirth was adopted by the mother's relatives. Older children (around 12 years of age) would care for themselves and any younger sisters and brothers. However, in times of need, a mother's kin group provided a secure base from which to tap needed resources. As a result, fostering arrangements and orphanages were not necessary.

In contemporary Thai society, however, low fertility has led to small family size, an increase in the number of nuclear families, and a reduction in the role of kin groups. The impact of maternal deaths, therefore, is greater today than in the past. Orphans have fewer people to turn to, and many must be cared for by society. Others enter the workforce early and earn their living as factory workers; still more become "street children". These youngsters are uneducated, homeless and are often forced to become beggars to eke out their living. To deal with their hardships, many turn to drugs, and this results in various types of social problems including increased juvenile crimes and prostitution.

AIDS orphans

This situation is worsening as Thailand comes under the grip of the AIDS epidemic. More women and children are becoming HIV-positive as the disease begins to afflict low-risk groups such as housewives and factory workers. For every pregnant woman who is HIV-positive, her child has a one-in-three chance of also contracting the disease. Those children who are afflicted will die within two to five years.

In large cities such as Chiang Mai in northern Thailand, where the HIV-positive and AIDS rates are high, concerted efforts are being made to address this problem. One method is to establish home care for HIV-positive and AIDS orphans. Instead of living in a hospital with its sterile, insensitive environment, such children without mothers are transferred to a home that provides better quality and more compassionate care. Without doubt, as maternal mortality increases from AIDS, this type of home will be in greater demand in the future.

Some orphans, who are not fortunate enough to receive home care, are often seen as a burden to their families. In a large Bangkok slum, about 35 to 40 orphans live among the spreading AIDS situation and other social problems brought on by overcrowded conditions and poverty. Fostering arrangements and orphanages are thus in growing demand.

So maternal mortality attacks the very heart of a family's future, not only in terms of child care but also of economics. Women make up about 69% of Thailand's labour force. Rates of premarital sex, pregnancy and abortion are also very high among this group, which places them at greater risk of contracting AIDS, transmitting it to their unborn child and later dying from the disease, only to leave another AIDS orphan in society's care. The future picture of maternal mortality in Thailand, therefore, is one of uncertainty, and will no doubt influence the nation's ability to expand and enter into the industrialized world.

The impact of maternal mortality on the individual, the family and society at large is like a pebble dropped into a pond, where the ripples of action and reaction reach out to all shores. In Thailand, the problem is causing particular concern. If a society does not have an adequate mechanism to manage or absorb the costs, and most importantly to care for the children involved, each person's and the society's quality of life will decline as will their health, livelihoods and the nation's developmental prospects. ■

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WHO/Zafar

Essential obstetrics . . . an important means of preventing maternal deaths

WHO Interview

Safe motherhood in Tanzania

"Previously, it would have been unimaginable for a leader from a women's organization to participate alongside medical doctors! Today issues of health are not only issues for the doctors, but issues for everybody."

No one knows exactly how many women die in pregnancy and childbirth. WHO estimates their number at 500 000 each year, 99% of them in the developing countries. It is in Africa that the risks are highest.

The Safe Motherhood Initiative aims to reduce globally maternal deaths by at least half by the year 2000. What effect will such an effort have on the lives of women in Africa? Kate Kamba, Secretary-General of the Union of Women of Tanzania, explained it to ***World Health*** during a WHO meeting on safe motherhood.

Safe motherhood covers all aspects which contribute to make women safe during the hazards of pregnancy and delivery. Some groups are more at risk than others, specifically girls under the age of 15 or women in their mid or late forties. Another aspect is the complications that arise during pregnancy and delivery because of the lack of awareness on the part of the mothers on how to manage themselves during pregnancy. For example, almost 60% of maternal deaths are caused by anaemia.

During pregnancy, you have to feed both yourself and the fetus. Whatever you eat, the fetus is not going to be sympathetic to you: unless you supplement your diet, the baby will take everything and you will be left with nothing! It is very important that during pregnancy you have enough fruit and vegetables, and when necessary – through a doctor or pharmacist – some iron tablets as well to supplement what you are eating.

Anaemia occurs because women are not actually aware that they need to eat a special diet. Sometimes they cannot afford to buy fruit and vegetables for the whole family; and, because traditionally in Africa women are the last ones to eat, they would consider themselves greedy if they were the only ones eating fruit and vegetables. This is a big handicap.

Also, because of economic hardships, women traditionally undertake many laborious activities and do not take rest. This uses up a lot of their energy, because they work right up to the time of delivery, instead of having some hours – or at least minutes – of rest each day, especially during the last months of pregnancy.

Education breeds awareness

Of course, there are some parts of Tanzania that are better off, and this depends on the level of education. In some areas, like the Kilimanjaro region, the local people have increased their education standard up to secondary level. So in these areas you find women who are quite enlightened on how to take care of themselves. Of course they have some cultural inhibitions, but if you compare this region to some of the very remote areas, you will find that people there are not even aware of the risks. Although they produce a lot of food crops, they have the highest malnutrition. They don't even eat vegetables – only pulses and maize meal – as there are no fruit or vegetables except during the wet season.

The Union of Women of Tanzania has branches at village level, with representatives at the district, regional and national levels. We hold meetings and workshops where we bring pregnant women together for training so that they can train others. We also provide them with some reading material to take away and keep for further use. We invite people from the Ministry of Health to attend our meetings and provide education. Family planning and health issues are on the agenda of all our meetings.

Opportunity for immunization

What we normally try to tell the women is that, when they are pregnant, they should attend a maternal health clinic. Secondly, they must be immunized because they don't know when they are going to deliver – whether at home or in hospital. Thirdly, we insist that they should rest. This needs a lot of community participation because, in most cases, the husbands don't understand; they think that the women have to go on doing things. We keep on telling such women that to rest is their right.

It is also important that they shouldn't have too many children. So we insist on family planning. We also train them to grow fruit and vegetables in the backyard gardens.

I really believe that this initiative is going to have a very big impact. Previously, it would have been unimaginable for a leader from a women's organization to participate alongside medical doctors! But there is a need for intersectoral coordination. This means that issues of health are not only issues for the doctors but issues for everybody.

Educate a mother and you educate a family

When you talk of the community, you talk of the woman and the father. But to make the Safe Motherhood Initiative successful, when you go into the household at the community level – the family level – it is the mother who is the key person because she is the manager of the home. She is the lawyer, the doctor, the cook – she's everything! So, if you educate the mother, you educate the whole family.

In our country, we have the human resources but we don't have the money. However, we can use the brains of the women to prevent rather than cure, because if we talk in terms of curing, we can't manage.

The mother and the child form a generation, so if we know how to protect them, we will have a healthy nation. People who are healthy are people ready to face anything – they are resistant to most of the problems which nature has put in the way of good health. ■

Ms Kate Kamba was interviewed by Ruth Landy of the Division of Health Education at the World Health Organization in Geneva. Her address is: Ohif Kuu Ndogo, S.L.P. 1473 Dar es Salaam, Tanzania.

WHO/T.Fay

Regular follow-up of each pregnancy helps prevent dangerous complications.

Women and tobacco

Amanda Amos & Claire Chollat-Traquet

When smoking amongst women was not as widespread as it is now, women were considered to be almost free from cardiovascular diseases and lung cancer. Unhappily, the situation has changed, and smoking kills over half a million women each year in the industrialized world. But it is also an increasingly important cause of ill health amongst women in developing countries.

A recent WHO Consultation on the statistical aspects of tobacco-related mortality concluded that the toll that can be attributed to smoking throughout the world is 2.7 million deaths per year. It also predicted that, if current patterns of cigarette smoking continue unchanged, the global death toll from tobacco by the year 2025 may increase to eight million deaths per year. A large proportion of these will be amongst women.

Despite these alarming statistics, the scale of the threat that smoking poses to women's health has received surprisingly little attention. Smoking is still seen by many as a mainly male problem, perhaps because men were the first to take up the habit and therefore the first to suffer the ill-effects. This is no longer the case. Women who smoke like men will die like men. WHO estimates that, in industrialized countries, smoking rates amongst men and women are very similar, at around 30 per cent; in a large number of developed countries, smoking is now more common among teenage girls than boys. In most developing countries, where it is generally estimated that 50 per cent of men and five per cent of women smoke, the epidemic seems not to have reached women yet. But as cigarettes become more widely available and more heavily promoted, trends are changing.

As women took up smoking later than men, the full impact of smoking on their health has yet to be seen. But

WHO/Zahn

Women took up smoking later than men – but it causes just the same diseases as in men.

it is clear from countries where women have smoked longest, such as the United Kingdom and the United States, that smoking causes the same diseases in women as in men and the gap between their death rates is narrowing. On current trends, some 20 to 25 per cent of women who smoke will die from their habit. One in three of these deaths will be among women under 65 years of age. The US Surgeon General has estimated that, amongst these women, smoking is responsible for around 40 per cent of heart disease deaths, 55 per cent of lethal strokes and, among women of all ages, 80 per cent of lung cancer deaths and 30 per cent of all cancer deaths. Over the last 20 years, death rates in women from lung cancer have more than doubled in Japan, Norway, Poland, Sweden and the United Kingdom; have increased by more than 200 per cent in Australia, Denmark and New Zealand; and have increased by more than 300 per cent in Canada and the United States.

There are dramatically increasing trends in respiratory cancer among women in developed countries, and the causal relationship of smoking, rather than air pollution and other factors, to lung cancer is very clear. In the United States, for instance, the mortality rate for lung cancer among female non-smokers has not changed during the past 20 years. During the same period, the rate among female smokers has increased by a factor of half. Smoking is already an important cause of cancer in many developing countries. In South-East Asia, more than 85 per cent of oral cancer cases in women are caused by tobacco habits.

Smoking also affects women's health in ways that are specific to women, and that puts them at added risk. Women smokers have higher rates of cervical cancer, while those who smoke and use the oral contraceptive pill are several times more likely to develop cardiovascular diseases than those who use neither. Smoking affects women's reproductive health, increasing the risks of earlier menopause, miscarriage and low-birth-weight babies – a major concern in those developing countries where a baby's health is already jeopardized by poverty and malnutrition. Smokers are more prone to osteoporosis, a major cause of fractures in older people, particularly post-menopause women.

Women's health is also affected by the smoking of others, that is, by passive or involuntary smoking; for, example, it has been shown that non-smoking wives of heavy smokers run a higher risk of lung cancer. In addition to these direct effects, we should not forget the indirect ones such as the additional burden in economic and non-economic terms that must be carried mainly by the mother as a consequence of morbidity and mortality of other family members from tobacco-associated diseases.

Protection, education, support

What can be done to halt and reverse the tobacco epidemic amongst women? The challenge is twofold: to reduce the already high level of smoking among women in the indus-

trialized world and to ensure that the low level of smoking in developing countries does not increase. In order to achieve these goals, all countries need to develop comprehensive anti-tobacco programmes which take into account and address the needs of women. Whilst these programmes should be culture-specific and tailored to meet the local situation, experts agree that to be successful they must contain three key elements: protection, education and support.

Young girls and women need to be protected from inducements to smoke. Tobacco is a multinational, multi-billion dollar industry. It is also an industry under threat; one quarter of its customers, in the long-term, are killed by using its product and smoking is declining in many industrialized countries. To maintain profits, tobacco companies need to ensure that at least 2.7 million new smokers, usually young people, start smoking every year. Women have been clearly identified as a key target group for tobacco advertising in both the industrialized and developing worlds. Billions of US dollars each year are spent on promoting this lethal product specifically to women. "Women only" brands, widespread advertisements depicting beautiful, glamourous, successful women smoking, free fashion goods, and the sponsorship of women's sports and events (such as tennis and fashion shows), are all part of the industry's global marketing strategy aimed at attracting and keeping women smoking.

This strategy has been highlighted by several tobacco journals which have carried articles on "Targeting the female smoker" and suggesting that retailers should "look to the ladies". Among the 20 US magazines that received the most cigarette advertising revenue in 1985, eight were women's magazines. In the same year, a study on the cigarette advertising policies of 53 British women's magazines (read by more than half of all British women) showed that 64 per cent of the magazines accepted cigarette advertising, which represented an average of seven per cent of total advertising revenue.

Research in industrialized countries has shown the subtle methods used to encourage young girls to smoke. The impact of such methods is likely to be even greater in developing countries, where young people are generally less knowledgeable about smoking hazards and may be more attracted by glamourous, affluent, desirable images of the female smoker. This is why WHO, together with other national and international health agencies, has repeatedly called for national legislation banning all forms of tobacco promotion, and for an appropriate "high price" policy which would slow down the "enthusiasm" of young women for tobacco consumption.

Resisting the pressures

Young girls and women have a right to be informed about the damage that smoking can do to their health. They also need to acquire skills to resist pressures to start smoking or to give it up. Several countries have developed integrated school and pre-school health education programmes which have successfully reduced girls' smoking rates; but this education should not be restricted to what happens in school. There are many other examples of effective cessation programmes in the workplace and primary health centres. Unfortunately, many women do not have the opportunity to be involved in such programmes, and programmes have generally been less successful with women than men. In countries where smoking has decreased, the rate of decline has been usually lower in women than men, and least amongst women with low education and income. This suggests that educational initiatives ought to be more sensitive to women's needs; they also ought to cover issues of particular significance to women – such as the gain in weight that sometimes occurs after they stop smoking.

They need support

In order for women to become, and remain, non-smokers they need support. Support over these difficult days when the addiction cycle is broken. Support to help them deal in other less damaging ways with the reasons that caused them to smoke. Many women use smoking as a coping strategy, for example to create a "space" in a day filled with the stress of bringing up children and having to face different types of work, often with little social support and on a low income. Environments need to be created which enable them to break free of this health-damaging behaviour, to make the healthy choices the best choices.

Smoking amongst women has already reached epidemic proportions and will continue to escalate unless action is taken now. Delays can only cause further suffering and deaths of women; this is why WHO's new programme on Tobacco or Health is giving high priority to action to protect women and children.

But what can be done to tackle this problem? Community health workers can develop health education programmes for young girls. Primary care workers can ensure that all women receive information, advice and support to help them give up the habit. Governments, national and international nongovernmental organizations, and WHO in particular, can act as advocates for women's health to ensure that the issue of women and tobacco is put high on the health and political agenda, by pressing for action to protect women. Strategies to this effect should involve health and educational services, community and women's organizations, the media and even the employers.

Only by exposing the previously hidden problem of women and tobacco, only by putting women in the picture, will we be able to secure major improvements in the health of women worldwide. ■

Dr Amanda Amos is a Lecturer in Health Education at the Department of Community Medicine, University of Edingburgh, Scotland. Dr Claire Chollat-Traquet is a Scientist with the Tobacco or Health Programme, World Health Organization, 1211 Geneva 27, Switzerland.

Women and water

Mayling Simpson-Hebert

WHO/M. Jarvis

In the rural Botswana countryside, when the groom's relatives arrive to fetch the bride at the end of the festive day-long wedding celebration, they come to "ask for water". This is the poetic and symbolic expression of a cultural reality. This bride, like most women in rural Botswana and in villages all over the world, will become the water-bearer for her family. Carrying water does not begin at marriage for such women. From the time they are old enough to carry a bucket, children of both sexes are also household water-carriers.

So how involved are the women of Botswana in the planning, operation and maintenance of their village water supplies? To what extent do they occupy higher posts at district and central levels, and what are their chances for advancement in a sector so vital to their lives?

The challenge for developing countries is to transform women from mere water-carriers into planners and managers of water supply systems.

With assistance from the Swedish International Development Authority, the Botswana government provided safe and reliable drinking-water within reasonable access to 80% of rural villages. This is a remarkable achievement in a country where 20 years ago nearly every village used traditional and relatively unsafe sources, such as ponds and dug wells. As Botswana has very little surface water, the programme has focused on an engineering solution: sinking boreholes near villages and piping the water to several standpipes evenly distributed around the village. Women and children come to the standpipes with buckets and carry the water home to be stored in containers.

Limited health benefits

Potential benefits from the new water supply systems are not being fully realized. A recent study showed that water-related hygiene practices in the home are generally not good, that households still fetch water on average seven times a day, and that only those homes very close to a standpipe have increased their consump-

Water has to be carried several times a day ...

... and that takes both hard work and hours of waiting

tion of water for hygiene purposes. Long queues at standpipes sometimes cause delays and people occasionally return to more convenient but unsafe sources.

Now Botswana is embarking on a programme to rehabilitate the older water supply systems and to deal with the health issues. As a result, questions of community participation and women's involvement are naturally arising. It is widely recognized that improving the water supply systems and keeping water clean are matters that rest largely in the domain of women.

Obstacles to women's fuller participation in Botswana are the result of traditional beliefs about the roles of men and women. As in many other parts of the world, women are not involved in initial planning because at the community level it is mainly the men who make decisions. Women role-models are needed for the women in villages to be involved in decision-making; but it will be difficult for women to penetrate this sector dominated by men. Women working in the water sector are mostly water supply operators who are paid less than the men who hold professional and managerial posts; very few women go in for technical training so they are confined to clerical jobs. Women themselves are not very confident that it is right for them to take technical jobs, even though they may be performing as well as or better than the men.

Building up confidence

However, these obstacles can be overcome. To step up women's participation in the water sector the world over, they have to be encouraged and recruited at the village level through campaigns giving them information on available technical jobs. Training and employment opportunities have to be offered, with equal opportunities for women to advance through the system as their male counterparts do. To build up women's confidence, certain training courses could be offered to women only, concentrating not only on technical skills but also on assertiveness and overcoming the stereotyped notion that men must do all the planning in the water sector.

Difficulties in involving women in the water sector have been recognized for a long time. In 1983, UNDP launched a research and development project called PROWWESS (Promotion of Women in Water and Environmental Sanitation Services) to find solutions to this problem. The result is a set of training tools for community participation, with the particular goal of involving women in planning and decision-making. These methods have proved effective in achieving women's participation in a wide variety of cultural settings.

With the involvement of the main users of water supply systems, the women, there is a better chance for these systems to be properly maintained and for the health benefits to be realized. Encouraging women's participation in the water supply sector will require a reorientation of priorities, such as putting people's development before the laying of pipes, and a greater commitment at every level to sustain the effort. ■

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Special AIDS threat to women

Rosmarie Erben

WHO/J. Hernandez-Cueva

"Only as we move into the 1990s has the world started to recognize the special threat that AIDS poses to women."

Men can protect themselves against the sexual transmission of HIV. Women find it more problematic. This is the difficult issue that challenges health promotion.

The condom is seen at present as the only effective preventive measure against sexual transmission of HIV. Yet, for many women – whatever the cultural context – to suggest to their husband or partner that he use a condom is seen as evidence of the woman's infidelity or is felt by the man as defiance or insolence. This results at best in painful discussions and a breach in the relationship, or at worst in the woman being beaten and abandoned. In cultures where the married woman is traditionally expected to bear many children, insisting on safer sex or refusing to engage in sexual relations is impossible.

These "facts of life" become even more dramatic when we look at the statistics. Some 200 000 women are expected to become ill with AIDS in 1990-1991 – more than the total of all those who have developed AIDS since 1980; a seroprevalence of 20 per cent in pregnant women causes infant mortality rates to increase by 36 per cent; about three million women are currently HIV-infected; and finally, over 100 million cases of sexually transmitted diseases are reported each year, pointing to the enormous potential for sexual transmission of HIV.

With the AIDS pandemic, as with many other health problems, women have often been viewed as "reservoirs of infection," posing a threat to men, and also to their babies, since vertical transmission has been recognized. This concept has denied the reality that women get infected either through sexual contact with men who, too often, refuse to use condoms, or through unsterile injection equipment used either in the medical environment or to inject psycho-active drugs.

The way we perceive ourselves and others, the way we express ourselves with our bodies, the way we use our bodies and protect ourselves or not from health hazards are all developed in relation to the culture in which we live, within an overall framework of individual and collective ways of living. The choices we are able to make vary from culture to culture, and are dependent on the living and working conditions common to our society.

Negative influences

The ability of women either to protect themselves from infection or, in case they are infected, protect others, is negatively influenced by several factors: *psychosocial*, *cultural*, and *legal barriers* to women's decision-making or independent action, the relative *lack of economic alternatives* for women, and their consequent dependence on men for support; women's *role as primary caretakers* of children, husbands or partners and parents; women's generally *lower literacy*, *limited mobility*, and *limited access to information*; and last but not least, cultural and moral *attitudes towards sexuality*. The vulnerable position of most women when it comes to sexual practices has to be recognized. Confronted by this situation, what can health promotion hope to achieve?

With the advent of AIDS, health promotion has taken on a sense of urgency. People have suddenly realized that behaviour – individual and collective – can dictate a sentence of death. In recent years, health promotion has helped gay men in the industrialized world to effect major changes in individual and group sexual practices. But only as we move into the 1990s has the world started to recognize the special threat that AIDS poses to women.

Health promotion uses five key areas as its framework for intervention: they refer to public policy, supportive environments, community action, individual skills and health services. In the *public domain* it goes beyond health care. It aims to combine complementary approaches, including legislation, fiscal measures and organizational changes leading to health and social policy that in turn foster greater equity.

Present approaches vary widely. In one country, for example, HIV-infected professional blood donors (virtually all men) are not isolated or punished. Prostitutes who test positive, on the other hand, are quarantined and held in prison long after their legally imposed sentences. Thirteen states in the USA have passed laws making compulsory the testing of individuals convicted of prostitution (85 per cent of those convicted are women). Proposals to test men have not been enacted into law.

Not really powerless

The need for *supportive environments* arises because fear and prejudice are the primary attitudes towards women who are HIV-infected or have AIDS. They may be denied medical assistance, rejected by their family and friends, and forced to leave their jobs. "If women can't get support from their families, they can get it from traditional organizations and women's groups. Women are not really powerless. It is a question of identifying our strength," says an organizer of the Zimbabwe Women's AIDS Support Network. The Network gives women the confidence to fight AIDS and suggests ways of doing so in a society where women have little control over the sexual behaviour of their menfolk.

The need to change social attitudes towards women who are HIV-infected or have AIDS, and to promote a more positive environment, is high on the list of health promotion priorities. Indeed one main objective is to establish closer communication between those affected by the virus and that part of society that defines itself as healthy.

An important aspect of supportive environments is "to make the healthier choice the easier choice" and facilitate non-risk behaviour. In the case of AIDS, this means easy access to condoms. Programmes of free distribution exist in some countries and are supported by WHO.

Examples of *community action*, especially through effective self-help and support groups that women have set up, can be found in many countries. Such groups in India, the Philippines, the Republic of Korea and Thailand have worked for better information, education and treatment of women with HIV infection. They have campaigned to have HIV-infected women released from detention and lobbied for the free distribution of condoms to tourists. They have fought for the rights of people with AIDS and their families. "EMPOWER" is a support group run by and for women working as bar hostesses in Bangkok.

Women's community action groups can play a crucial role in pressuring governments to change

The concept of women as "reservoirs of infection" denies the reality that women get infected through sexual contact with men, as well as by drug abuse.

laws or reorient budgets to ensure that funds are allocated for AIDS prevention and care. Increasing the involvement of nongovernmental organizations, particularly at the community level, is a must.

What about the *individual?* The process of "enabling people to increase control over their health" is at the heart of health promotion. Hence the focus on providing information and enhancing life-skills. Most studies carried out in various cultural and economic contexts reflect misconceptions and considerable confusion about HIV transmission and AIDS. So it is important to study the knowledge, attitudes, beliefs and behaviour of women and link the results to information and education activities. How to reach women in certain cultural settings and how to communicate with them are also major questions for health promotion research.

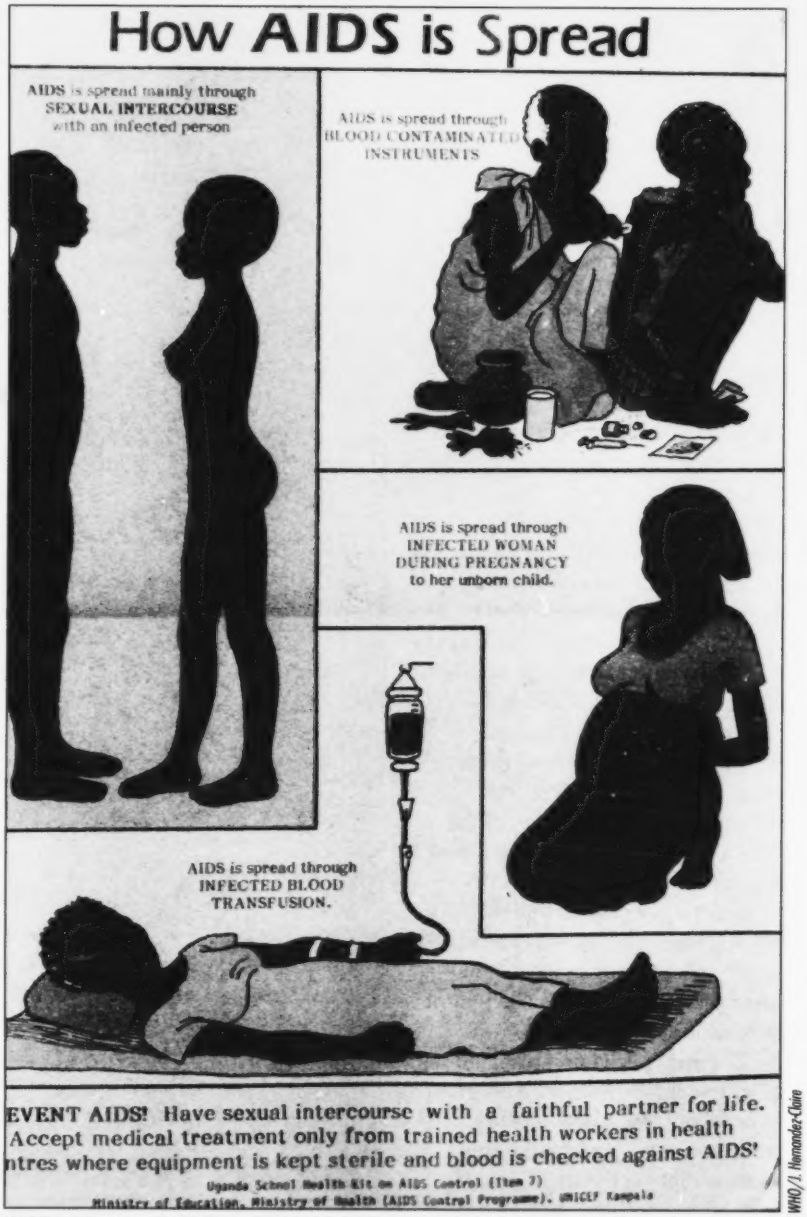
"Safer sex" workshops are an important component of health promotion, both by encouraging women to think creatively about sexuality and by providing practical information. They can be run by trained female health educators, but members of peer groups can also be trained and usually prove extremely effective. In developing personal skills, it is vital to use the language of the women themselves and to rely on interactive processes.

As for the *health services*, the prevention and control of HIV infection must be closely tied with existing services for women, mothers and children. All services providing maternal and child health care, family planning and treatment of sexually transmitted diseases must ensure that HIV/AIDS activities are integrated in their own activities. In addition, women must have access to safe blood supplies and safe medical injections. In the developing world, most blood transfusions are given to women and young children in connection with childbirth and its complications.

On the broader level, health services need to be more sensitive to cultural needs and client expectations. Too often, health care is given from the perspective of the health care providers irrespective of how appropriate this may be for the patient. What women desperately need, very often, is more attention and support.

Finally, health promotion cannot be achieved by the health sector alone. It demands coordinated action by governmental and voluntary organizations, by local authorities, industries and the media. It offers opportunities for new, broad-based health-oriented action. In the case of women and AIDS, it is directed against the stigmatization and social disadvantage experienced by those affected by the disease. It seeks to enable women to say "No" to sex risk behaviour, and this means giving them knowledge, social support and economic independence. In short, health promotion calls for concrete and efficient action, tolerance, equity and solidarity. ■

Dr Rosemarie Erben is the Health Promotion focal point for the Global Programme on AIDS, World Health Organization, 1211 Geneva 27, Switzerland.


How AIDS is Spread
AIDS is spread mainly through SEXUAL INTERCOURSE with an infected person
AIDS is spread through BLOOD CONTAMINATED INSTRUMENTS
AIDS is spread through INFECTED WOMAN DURING PREGNANCY to her unborn child.
AIDS is spread through INFECTED BLOOD TRANSFUSION.
EVENT AIDS! Have sexual intercourse with a faithful partner for life. Accept medical treatment only from trained health workers in health ntres where equipment is kept sterile and blood is checked against AIDS!
Uganda School Health Kit on AIDS Control (Item 7)
Ministry of Education, Ministry of Health (AIDS Control Programme), UNICEF Kampala

WHO/I. Hernandez-Cuevo

A poster from Uganda explains the transmission of HIV infection.

Women, sexuality and AIDS in Brazil

Maria José Oliveira Araujo & C. Simone Grilo Diniz

Barrier methods of contraception, and above all the sheath, help to prevent not only unwanted pregnancy but also sexually transmitted diseases and AIDS. This is a priority message for family planning programmes in today's world.

Traditionally, family planning programmes have placed little emphasis on the context in which sexual relations take place or on the ill-treatment of women at home and in society. They have shown little solidarity with women's efforts to improve their social position. Only recently, within the concepts of the comprehensiveness and quality of care, have such issues as the hierarchical relationships between the sexes, domestic and sexual violence, and non-consenting sex begun to be discussed. Considering the seriousness of these problems, they are still discussed very timidly.

Public opinion surveys show that the idea is still prevalent that HIV infection/AIDS occurs only in "risk groups", identified as people whose sex life does not follow conventional patterns, such as male homosexuals, prostitutes and the promiscuous. The facts are very different: recent worldwide data show that women now represent a considerable proportion of all infected persons. If men and women are to be free from such infection, they need to practise safer sex, above all by using the condom. For women this presents an additional problem, since it is the men who need to use it, very often in contexts where the women have little or no control over their sexual availability, and where the refusal of sex or the suggestion of using a sheath could bring the risk of rows, violence or abandonment by the partner.

Another serious problem with family planning programmes has been the emphasis on high-technology methods that are extremely effective but over which, again, the woman has little or no control; they involve a high degree of dependence on family planning services, and provide no protection against sexually-transmitted diseases. In the countries of the South, barrier methods are used much less than in the countries of the North. Priorities in the South are based on reducing population growth and on the belief that women could not cope with a method that they had to apply themselves, whether through lack of education or because they carry too little weight in their relationship with their partners. In Brazil, as in other countries, the cost of motherhood for women (material and emotional cost, extra work, etc.) leads 85% of female contraceptive users to opt for pills or surgical sterilization.

WHO/G. Diez

Women's efforts to improve their social position have still had little impact on family planning programmes.

A further problem is that, in some countries, while women are required to be monogamous, the man is allowed to have other relationships.

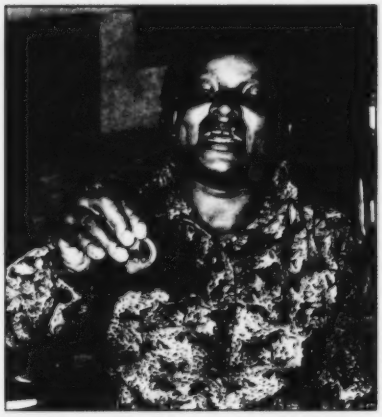
Family planning and AIDS

The AIDS epidemic makes it extremely urgent for society as a whole, and for family planning programmes in particular, to reformulate their role on the basis of an understanding of who decides how, when and why to have sexual relations, and to honour a commitment to promote greater awareness and negotiating power for women. Very often, such programmes still offer the only possibility of access to any kind of social service, especially in the context of overall poverty in the countries of the South.

The worldwide movement of women has stepped up its struggle for access to safe contraception and abortion, and for wider recognition of their reproductive rights. The fight for these rights introduces a new logic into the efforts to build up women's citizenship, by regarding motherhood as useful work, and thus as something that they should freely choose with the support of society. Thus women become active participants in reproductive and sexual choices. In the countries of the South in particular, this implies radical changes in the relations between the sexes. As rates of HIV infection/AIDS among heterosexuals increase, the relationship between socioeconomic status and risk behaviour becomes clearer – and once again women are the poorest among the poor. In São Paulo, Brazil, where AIDS is already the leading cause of death among women aged between 20 and 35, these women have substantially lower incomes and less education than men with the disease.

There is an urgent need to increase the available financial resources and to change family planning policies:

- By incorporating the awareness that the sexual relationship is one that empowers people at different levels. Everything suggests that the most effective solution is to increase the negotiating power of women.



WHO/H. Anenden

Promoting condom use. Barrier methods help to prevent unwanted pregnancy as well as sexually transmitted diseases and AIDS, and cervical cancer.

WHO/L. Taylor/SCF

To plan their families and practise safe sex, women need greater negotiating power vis-a-vis their partners.

- By re-evaluating family planning methods on a basis of the risks of HIV infection, either because the methods do not prevent it or because they increase the risks. For example, the IUD presents a risk by facilitating pelvic infection. In Brazil, the high rate of tubal ligations makes women more vulnerable, since they find it harder to insist on a barrier method when there is no longer any need for contraception.

It is vitally urgent to give priority to methods that combine contraception with prevention of sexually transmitted diseases. Barrier methods, which help to prevent an unwanted pregnancy as well as these diseases and cervical cancer, must be given priority if we are committed to the sexual and reproductive health of women – indeed of the whole human race. ■

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AIDS: no immediate demographic repercussions

Is there a danger that AIDS might depopulate the planet? The question is constantly asked, and it reflects a real but unjustified anxiety. Despite the vast scale of the epidemic in every continent and the dramatic inroads that it is making, the world population is not threatened with self-destruction as things stand at present. The five countries hardest hit by the epidemic are grouped in sub-Saharan Africa. Between 7% and 9% of the population of Malawi, Rwanda, Uganda, Zambia and Zimbabwe are infected with HIV, but rates in the big cities and more seriously affected zones are approaching 25%.

While the impact of AIDS in terms of individual suffering and of social and economic cost remains intolerable, in demographic terms it is barely noticeable. The fact is that the rate of demographic growth of these countries exceeds 3%, and this largely compensates for the negative effect of deaths from AIDS. Paradoxically, the poor performance of organized family planning programmes (an average of only 13% using contraceptives) protects these countries from recording a drop in population. The effect would be quite different if contraceptive use were as popular in these countries as in other continents. In the present situation, only if as many as 50% of the population were infected with HIV would there be immediate demographic repercussions.

AIDS: mother to child

David L. Heymann

For a child to die of AIDS is tragic; even more tragic is for the mother to discover that the baby got the infection from her and that she herself may soon die, leaving the other children which she has borne without a mother. These are among the legacies of AIDS – a pregnant woman infected with the human immunodeficiency virus (HIV), the cause of AIDS, who passes it unknowingly to her unborn child. If the father is infected with HIV as well, those other children will one day become complete orphans.

AIDS occurs all over the world; WHO now estimates that over three million women are already infected with HIV, and infected pregnant women are thought to have a 15 to 45 per cent chance of passing the virus to their children before, during or shortly after birth. Most of these women do not know they are infected. Adults can be infected for as many as ten or 15 years without developing any signs or symptoms of AIDS. Because HIV infection does not reduce fertility, infected women may have many children while they are infected with the AIDS virus; scientists do not know why some of these children will be infected, while most of them will not.

WHO/E. Mandelmann

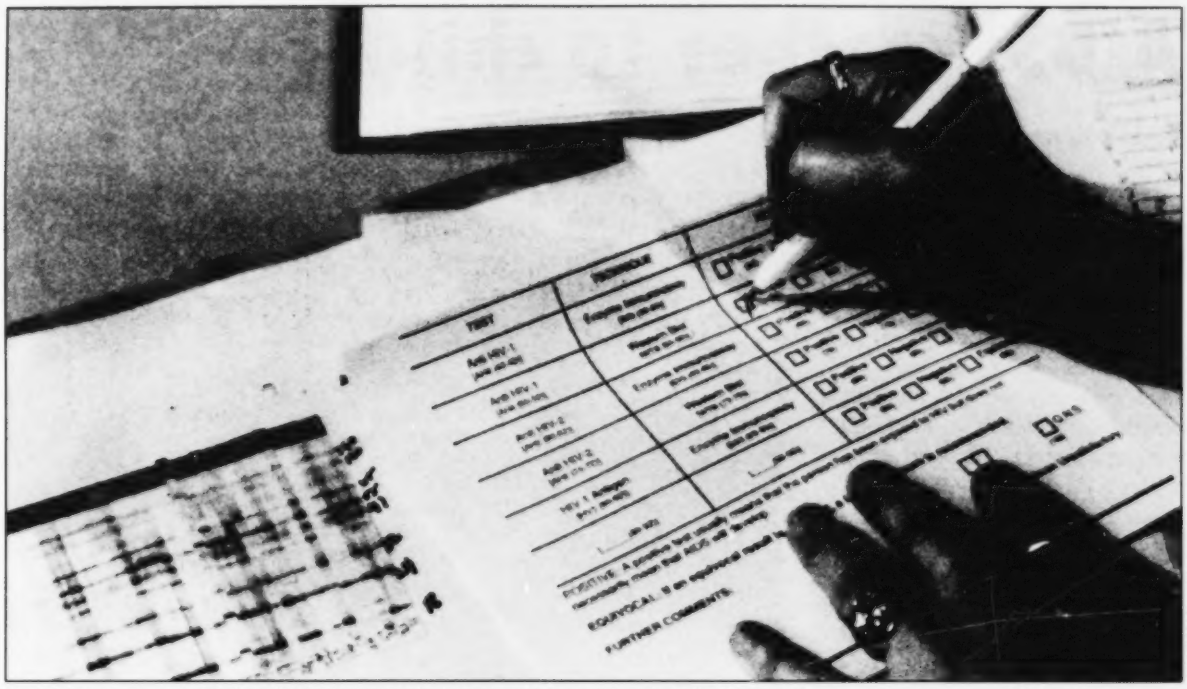
A healthy newborn baby protests against the world's injustices. In fact, the world is witnessing a rapid advance of AIDS among children.

Ten million orphans

WHO estimates that over half a million children have already been infected with the AIDS virus, and that by 1992 this number will have doubled. During this same period, it is estimated that over three million uninfected children will have been born to mothers infected with HIV and that, by the year 2000, there will be over ten million uninfected orphans whose parents have died of AIDS.

In many countries where today the threat from AIDS is greatest, it was unheard of for children to have no family to care for them. If a child's mother and father died, other family members usually assumed responsibility for taking care of the child until adulthood. Now, however, in some of these countries, extended families are already overwhelmed by other children whose mothers and fathers have died of AIDS, or the remaining adults are themselves sick with AIDS, and unable to care for them. Some family members do not accept even uninfected orphans because of the false belief that they will bring them bad luck or even infect them with the AIDS virus. Orphans have therefore become a tragic legacy of AIDS in many countries around the world which do not yet have the necessary social structures to cope with children who have no families.

At present the course of infection in children with the AIDS virus is not completely understood. An un-



WHO/CDC Atlanta, USA

The "Western blot" technique is a way of detecting the antibodies transmitted from the mother to her child.

known percentage of children who are born with HIV infection develop signs and symptoms of AIDS during the first year of life and die before their second birthday. Others become ill later in infancy and early childhood and may survive to the age of four or five. Still others remain asymptomatic well into school age.

Many childhood diseases, such as measles and diarrhoeal diseases, are more severe in children who are infected with HIV. Therefore, WHO and UNICEF recommend that all children who are born to HIV-infected mothers, whether or not they themselves are infected, be immunized against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles and tuberculosis. One exception is that children who show signs of advanced HIV-infection should not be vaccinated with BCG, the vaccine that prevents tuberculosis, because this vaccine can cause serious side-effects in these children. HIV-infected children who have signs of advanced infection should, however, like all children, be immunized with all the other usual vaccines of childhood.

In the rare situation when a woman has been infected with the AIDS virus through transfusion of infected blood shortly after delivery, it has been shown that the AIDS virus could be transmitted through breast-feeding. Such instances are very uncommon and the risk of becoming infected by breastfeeding is low. In fact, the risk is much less than the risk of other infections, including diarrhoeal diseases, which can occur if the baby is not breast-fed. 'WHO therefore recommends that breast-feeding by the mother should continue to be actively promoted for all infants whether or not their mothers are infected with the AIDS virus.

One means of reducing the number of infants who are infected with the AIDS virus before or at birth is for women who are considering pregnancy, and their sex partners, to undergo voluntary, confidential testing for HIV antibodies. If one or both members of the couple are shown to be infected with HIV, they can then decide whether or not to continue with attempts to have a child, taking into account the risk of transmitting the infection to the infant during pregnancy. This decision may be extremely difficult, since having a child is very important for many couples. Furthermore, if the man is HIV-infected and the woman is not, she may become infected as well while attempting to become pregnant.

Questions and answers

Research on mother to child transmission is focusing on the question of whether there is a biological reason that the AIDS virus is transmitted to infants in some pregnancies only. Answers to this and other related questions will perhaps provide a basis for specific treatment, or eventually a vaccine, that will help to prevent transmission of the AIDS virus from women to their infants.

Until more about mother to child transmission of HIV is understood, women and their children who will die with AIDS and children who are uninfected and left as orphans remain tragedies of the AIDS epidemic that demand both compassion and responsible decisions about sex and reproduction. ■

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Pregnancy and malaria

Bernard J. Brabin

In the early 1970s a Dutch doctor, Francis Kortmann, began to study the problem of malaria in pregnant women at a rural hospital at Muheza in Tanzania. Some years later in a small Dutch library I accidentally came across his thesis written on this subject. The clinical, parasitological, obstetric and immunological details he reported in his studies of several hundred women convinced me that, when malaria occurs during pregnancy, it poses a major health problem in tropical countries.

Highly vulnerable

Since that time I have been involved with field research projects in western Kenya and coastal Papua New Guinea which have given priority to investigating why pregnant women are at special risk of getting malaria, the size of the problem, and how it can be prevented. These studies have shown that, in areas where malaria is transmitted year-round, pregnant women have frequent episodes of malaria from early to mid-pregnancy.

In their first and possibly second pregnancy, women are especially vulnerable, because in later pregnancies they build up more resistance to the malaria infection. One of the surprising findings from these studies was that most women did not complain of acute symptoms of malaria such as high fever and shivering episodes. It would appear that, despite these recurrences, the infection generally remains partly controlled by the mother's immune system. As a result the infection may often be clinically unrecognized, and it is only when a blood sample is taken for a malaria smear that it is diagnosed. This is why pregnant women are at particular risk.

Low-grade infection can lead to an increasing degree of anaemia in the mother, which in some cases develops into severe anaemia by the time of delivery. If the mother then loses blood during childbirth, her life is in danger.

Women are more vulnerable to several infections during pregnancy because their immunity is either not yet fully formed or has been altered. Malaria is only one of the factors which increase the risk for ill-health or death in pregnant women, but when associated with anaemia it is probably the most important one, especially if the level of immunity to malaria is low. Anaemia from other causes such as iron deficiency is very common in many tropical areas, further increasing the risk. Often 70% to 80% of pregnant women in malarious regions are anaemic. This situation can be improved by controlling malaria transmission (for instance, by preventing mosquito breeding or using bednets) and by treating the anaemia with iron and folic acid.

In areas where malaria is endemic, pregnant women should be given antimalarial drugs and iron and folic acid supplements at their first antenatal visit whether or not they have symptoms. Ideally this should take place early in pregnancy as this is an important period for fetal growth. If delayed until later in pregnancy, the benefits to the mother and fetus may be limited.

Pregnancy in young girls increases the risk of complications from malaria and anaemia, because their own growth process is not yet completed; this leads to delivery complications and to competition between the girl and the growing fetus for nutritional requirements. In areas with high levels of malaria transmission adolescent girls should be screened for anaemia even if they are not pregnant. Those with anaemia should be treated so as to reduce the risk of starting their first pregnancy in an anaemic state.

Retardation of fetal growth, with resulting low birth weight, mainly affects babies born from first pregnancies. Pre-term delivery may also result from malaria, but this more commonly occurs in women with low immunity to malaria, such as those from non-endemic areas. In some endemic areas, as many as 40% of babies of first pregnancies have low birth weight because their mothers had malaria.

Clearly it is important to protect pregnant women from malaria. The drugs currently recommended for prophylaxis are limited to chloroquine (weekly) and proguanil (daily). Both are considered safe drugs to take during pregnancy. Because the parasite is becoming resistant to chloroquine, other drugs are being sought for use in pregnant women. The best advice for non-immune women would be not to travel to an endemic area if they are pregnant. Women who live in malarious areas should attend an antenatal clinic as early as possible in order to receive the necessary care. In areas where this is not possible, studies have shown that the distribution of antimalarial drugs by village health workers can offer real benefits for mother and child. ■

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WHO/G. Gramiccia

Women in developing countries are often anaemic. If they become pregnant and have malaria, their health is in serious danger.

Nursing in the years to come

Margretta Madden Styles

WHO/Zafar

Nurses are becoming increasingly autonomous and moving into the field of independent practice.

Particularly in countries where many are illiterate, nurses are investigating new approaches to make community members partners in health care delivery, and not merely passive consumers.

In Mexico, nurses are educating rural inhabitants about nutrition and disease prevention. In Africa, they are counselling HIV/AIDS patients and families in their homes and explaining to whole communities in town hall meetings how to prevent the disease. In Italy, a nurse-run independent employment agency answers nursing needs at homes and in institutions. And in the USA, nursing centres give families and the homeless direct access to both curative and preventive care.

These are a few examples of how nurses worldwide are shaking off tradition and responding to new health needs, not only in health care facilities but in communities, homes, schools, the workplace and even "in the street". Their reach is also far wider, as they search out the more vulnerable: the poor, refugees, substance abusers, the elderly, persons with HIV/AIDS, and women.

As health care systems are being restructured, funding services diversified and hospital stays shortened, nurses are collaborating with other health professionals to provide the necessary skilled care, inside and outside hospitals. They are also becoming increasingly autonomous, creating independent support services that make the self-employed nurse directly accountable to the client.

Nurse-centred consultation models are already proving their success in helping families to care for low-weight babies discharged too early from hospital, the elderly, the handicapped and the chronically ill or mentally ill. And the trend towards independent practice is occurring not only in industrialized countries. In Benin, for instance, nurses recently began practising independently in response to a government freeze on nursing posts in hospitals.

In their campaigns to assure quality patient care, nurses are forming partnerships among themselves and with other health professionals, networking across borders, and working together to develop standards in their countries.

Innovative models

One foretaste of what nurses can achieve in primary health care is taking place in the Republic of Korea, where over 2000 community health posts are being staffed and managed wholly by specially trained community nurses. The 1994 Sasakawa Prize was awarded to the instigator of this project, Dr Mo-Im Kim, Dean of Yonsei University's College of Nursing in Seoul (a WHO Collaborating Centre for Nursing Development) and former President of the International Council of Nurses (ICN). This programme provides not only high quality care in remote areas but also contributes to overall community development.

Another new model for primary health care – this time to meet the needs of the frail elderly living in cities – has been developed by St

WHO/Zafar

To respond to health needs, nurses need to go out and meet people, even in the street.

WHO/Zafar

Nurses today are keeping pace with the advances of health technology.

Luke's College of Nursing in Tokyo (also a WHO Collaborating Centre for Nursing Development). So far, it has established: 1) a nursing home for the elderly; 2) a volunteer support team consisting of district welfare commissioners, police, firemen and lay citizens; 3) a home care support centre; and 4) a programme to study ways of improving housing arrangements.

Education has been and will be the key to nursing's evolutionary progress as a profession and the fulfilment of nurses' multiple roles in primary health care. Besides illness prevention, health promotion and community-based care, nursing curricula in the future will put more emphasis on health care economics so as to arm nurses with the knowledge to implement cost-effective care. Courses will also include health policy and planning so that they can work better with decision-makers and ensure that the quality of care is not threatened when health services are rationed. Already in countries where much of the population will be illiterate for some time to come, nurses are investigating new approaches to make community members partners in health care delivery, and not merely passive consumers.

The importance of nursing research to scientific bodies of knowledge has been highlighted by the recent establishment of the National Institute for Nursing Research at the National Institutes of Health in the USA. Its purpose is to provide a strong scientific base for nursing practice.

New technologies

Nurses are also keeping pace with the fast-changing medical technologies by becoming highly skilled in the new technologies and in such specialties as nurse midwifery, anaesthesia, cancer and other illnesses. A significant change in nursing practice will result from computer-based patient records which give a picture of the patient from birth to death and will further empower consumers to be responsible for their own health. With the focus on wellness, nurses will thus be more productive, responsible and accountable for patient outcomes.

In developing countries where the AIDS pandemic is already rampant, nurses and other health professionals will also be battling with the re-emergence of such preventable diseases as malaria and tuberculosis, and the populations' sudden vulnerability to new infections. All of these dramatically increase the need for nursing care to the severely ill and the dying, as well as for health education, particularly environmental hygiene.

WHO/L. Gubb

There is a rapidly increasing need for nursing care of the chronically sick.

As mobilizers in communities, nurses are joining the townspeople in lobbying for accessible health facilities and for such basic infrastructure as roads, drinking-water, sewage and refuse disposal, transport to clinics, child care centres, and maintenance of the cold chain for vaccines.

Nurses around the world will continue to be an important link in the health care chain. A prime motivator in this regard is the International Council of Nurses, which is working through its 114 national nurses' associations to strengthen nursing forces worldwide. And to give nurses adequate support and recognition in all countries, WHO has created a Global Advisory Group on Nursing and Midwifery charged with finding "innovative and practical options to ensure the optimal contribution of nursing for the health of all people in the world." ■

Dr Margretta Madden Styles is Professor Emeritus at the School of Nursing, University of California, San Francisco, and President of the International Council of Nurses, 3 place Jean-Marteau, 1201 Geneva, Switzerland.

"Miss, we cannot read or write"

Maureen Minden

After training, traditional birth attendants in a remote part of Nepal are passionate in their desire for better treatment of girl children.

WHO/L. Taylor

Monitoring pregnancies is a key element for mother and child survival.

Nepalese women say that "in childbirth, death comes for women". After a successful birth they say "I survived". Maternal mortality in Nepal is under-reported at a figure of 8.5 per 1000 births; a study two years ago in Kavre assessed it at 12.1 per 1000. Infant mortality is more than 123 per 1000 live births.

For the past three years in Kavre, a middle-range mountainous district in Nepal, auxiliary nurse-midwives and I have been teaching maternal and child health care to village women. Divisive factors seem to overshadow the commonality of human needs; the mountain terrain, ethnic and language differences, the caste system, gender discrimination and illiteracy – all these seem to fragment our efforts to spread health education.

As a member of the British Voluntary Service Overseas, I work within the government health care system as a district public health nurse. There are nine health posts, the most remote requiring two or three days' walk. Under the Division of Nursing's traditional birth attendant (TBA) training programme, we have taught at all of the health posts: 15 women at each post, one trained TBA for every two to three villages. A drop in the ocean, but a beginning!

The programme involves a ten-day basic course, a four-day refresher course within a year, and six two-day supervision meetings every month. The women are illiterate. The training is minimal, designed in the face of such constraints as: limited funding; no staff at some health posts; no roads or transport in most of the district; some TBAs living two to three hours' walk from the health post; and women tied to the home and the land – with planting, monsoons, and harvesting from June to October.

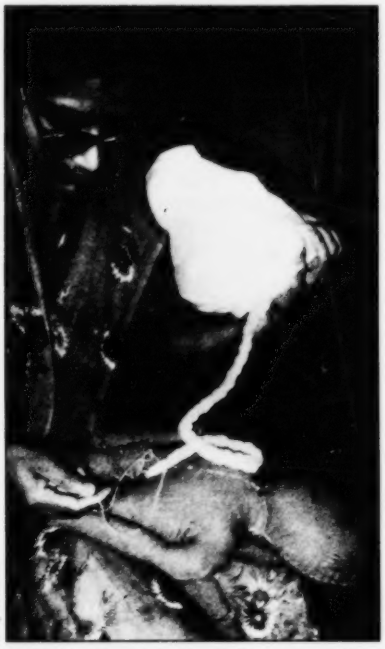
Cultural beliefs and practices vary, but in Kavre certain views seem to prevail, the most influential being that menstrual blood, and consequently the blood of childbirth, is a source of pollution. Very often women give birth alone, thereby not polluting anyone and avoiding the obligation to give gifts and do purification rites.

The mother-in-law is traditionally the birth attendant for her daughters-in-law. Sometimes she attends only the first birth, the women giving birth alone after that. Some, having gained a reputation as wise, may be called by other families in the community if a birth is difficult or complicated. Prior to taking the course, with no knowl-

edge of the germ theory or sources of infection, TBAs used to advise women to give birth in the animal shed to avoid polluting the home.

Since there is no knowledge of the uterus and its functioning in labour, a cloth is tied tightly around the abdomen to prevent the child from "going upwards into the mother's heart and killing her." If the placenta is not delivered within a few minutes, the woman's hair is pushed down her throat to make her vomit in the belief that this will help her to expel the placenta. After birth there is no effort to control bleeding; this "bad blood" (menstrual blood of the months of pregnancy) must come out!

Nutrition is a serious problem. Many foods are restricted in pregnancy as harmful, including oranges, tomatoes, pumpkin, honey, and sometimes green leafy vegetables. The connection made between the pregnant woman's nutritional status and that of the baby growing within her is obscure. The postnatal diet is white rice, herb broth, and ghee (clarified butter); everything else legumes, peas, green vegetables, fruit, milk, and yoghurt – is withheld. The mother's intake of water is severely restricted since it is thought to give the baby stomach pains.



WHO/M. Minden

A doll used in training TBAs.

At the beginning of the course, the TBAs and I discuss our different backgrounds. They tell me, "From when we were little we never had the chance to go to school; Miss, we cannot read or write". We discuss their experience and skills, based on their care of families, homes, fields and animals. After a few days of classes, they say "Look at us. Who would have thought we would be getting education!" As they develop some understanding of our bodies in health and illness, and aspects related to childbearing, they begin to believe that perhaps, even in Nepal, so many women and babies need not die and they themselves could be instrumental in improving health.

The Division of Nursing's programme has developed flipcharts and a teaching manual for village level, but demonstrations, directed discussion and role-playing bring the information alive. The TBAs are passionate in their desire for better treatment of girl children. Today they advise pregnant women about nutritional needs during pregnancy and after the birth, as well as the need for tetanus immunization, giving birth in a clean place, management of labour, early recognition of problems, safe cord-cutting techniques, early care of the baby, family planning and much, much more.

These TBAs are eager to share their experiences, and sometimes thank the district nurse-midwives, who are now their role models, for clarifying some problems they have long struggled with. They tell them, "You teach us. We can improve life in our villages." ■

WHO/L. Taylor

Learning how to read and write: a right long denied to Nepalese women.

Mrs Maureen Minden is a state registered midwife and has worked in Nepal as a member of the British Voluntary Service Overseas (VSO). Her address is 7 Hill House, Southside, Steeple Aston, Oxfordshire OX6 3RY, England.

Home care in Denmark

Slim Allagui

WHO/J. Schytte

Even when they enjoy good health, old people often need help in their daily activities.

The home nurse is the key personality in Denmark's policy for the elderly.

The alarm clock goes off at half-past five in the apartment of Stine Nielsen, a 25-year-old home nurse, in Frederiksberg, outside Copenhagen. She prepares breakfast for her six-year-old son Peter, and a sandwich for him to take to the kindergarten. One hour later she gets on her bicycle, leaving her husband Jan, a biologist, to feed and dress the child.

Stine starts work at seven o'clock in the communal centre for home care in Frederiksberg. The centre has 90 nurses, 41 auxiliary nurses and 552 house cleaners to look after some 5000 old-age pensioners, who are for the most part in good health but have to be watched in case they need help in their daily activities. In her office, Stine organizes her working day between 7 and 8 a.m. "I make between 10-15 home visits each day so they have to be planned almost by stopwatch – efficiently but without forgetting the vital human aspect, so that the pensioners don't get the impression they are being visited by some pre-programmed robot."

She goes on: "There are two categories of pensioners, those who are basically well but need help every day – to take their medicines, to remind them that it is important to eat and drink, and so on; and the others who are sick, but have either family care or are not so disabled that they need to be in hospital or have to end their days in a rest home."

The home nurse, a century-old institution (in fact 101 years old) in Frederiksberg which was originally administered by a group of nuns, is the key person in Denmark's policy for the elderly. That policy rests on a simple philosophy: "To let the elderly live as long as possible in their own environment, because they feel better there and the cost is much lower for the community which is financially responsible for them."

Stine and her colleagues are the ones who decide whether the pensioners can continue living in this "more human" manner, or if they should consider going to a rest home where residents are mostly aged over 80 and have greater need of care. Frederiksberg has 6503 such old folk; 163 of them are over 100 – mostly women.

On her bicycle, with her nurse's bag on the luggage-rack, Stine sets off on her first visit – to the Tenberg couple, childless and in their eighties, living in an attractive three-room flat beside the royal park of Frederiksberg.

The husband, Arne, opens the door with a welcoming smile for Stine – the only contact he has with

the outside world. "How is Ada?" she asks. "Not too bad," he replies. "But she is complaining and I can't find out why, perhaps because she has to go to the dentist tomorrow and she hates that." His wife Ada, totally paralysed for the past four years, sits in an electric wheelchair and contemplates the flowering trees in the park. Stine tenderly takes her hand. "Don't be afraid, Stine is here," says Arne to reassure her. Ada has difficulty pronouncing words intelligibly.

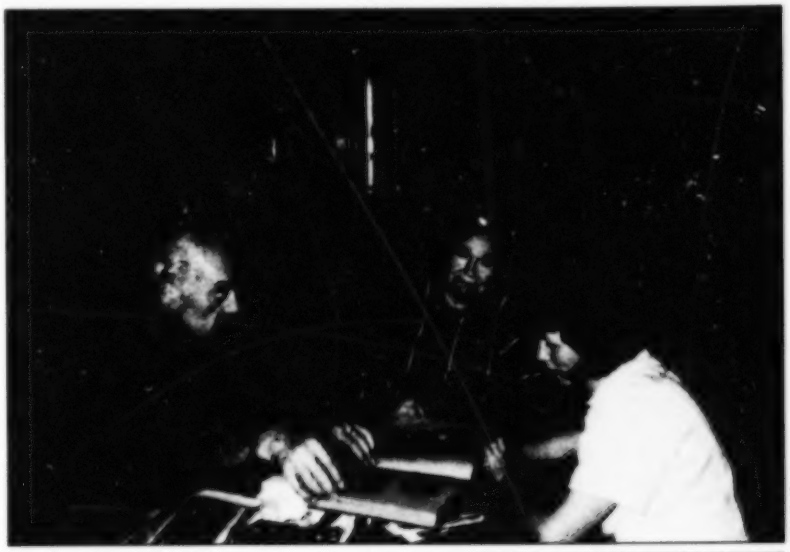
For four years, Arne has been a reluctant prisoner in this apartment. "When Ada first got ill, I thought I would be able to manage on my own, but then her condition worsened. They suggested putting her in an old pensioners' home but I refused; you can't put away someone with whom you have spent 55 years of your life," he confides, stroking Ada's newly washed grey hair.

"The Tenberg family gets three visits a day from the nurse and auxiliary nurses", says Stine; "one in the morning, one in the afternoon and one in the evening, to help Ada to take a bath, watch over her health, dress her and put her to bed."

A house-cleaner paid for by the commune comes twice a week for two hours to clean up. "That's the only time off that I get," says Arne, who is getting ready to run some errands, pay bills at the post office and do some business at the bank. Three times a week the couple receive some frozen foods. "The rest of the time I prefer to do the cooking myself, because Ada loves the tasty little dishes that she used to make." With every sign of appreciation, he adds, "The home nursing system is the only thing that helps us to stay together."

In the house, the commune has provided the couple with three wheelchairs, an electrically-operated bed, a bathroom specially equipped for the handicapped, and a little electric lift near the staircase for their rare trips into the town – for blood tests at the hospital or to the dentist. In the evening, the nurses exchange their bicycles for the seven red service cars, each with a telephone linked to the ambulance services. "There are people with cancer, people with AIDS, people seriously ill, who would rather die at home and who have to be watched 24 hours out of 24," explains Mie Mogensen, one of the two people in charge of the Frederiksberg home-care centre. With 27% of people aged over 67 in a district of 86 000 inhabitants, the home nurses are kept busy working in three shifts right round the clock.

"As people are living longer, there is going to be more and more need for home care," she forecasts, adding, "the present system functions well, even if certain patients sometimes grumble that they see too many different faces of the staff and would prefer to get to know just one who would become part of the family and of their everyday life. We may have to re-model our system to respond better to the needs of the next generation of the elderly. But the system we have now, for all its drawbacks, is the best we have found so far." ■



WHO/S. Allagui

For the old couple confronted with disease, the visiting nurse is part of the family.

Mr Slim Allagui is a journalist with Agence France-Presse. His address is Mikkel Bryggersgade 5, 1460 Copenhagen, Denmark.

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